PERINEAL MANAGEMENT DURING CHILDBIRTH AND SUBSEQUENT DYSPAREUNIA

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Summary: Sexual function following childbirth was studied by means of a retrospective postal questionnaire. Dyspareunia measured on an analogue scale relative to pre-pregnancy values (mean values) was significantly greater three months after a mediolateral episiotomy (35%) than after vaginal delivery with intact perineum (9%) or Caesarean Section (16%) and similar to the value following second degree perineal laceration (29%). At 12 months the latter had returned to pre-pregnancy values, while that following episiotomy remained significantly elevated (17%).

INTRODUCTION

Episiotomy may be performed because of specific complications of pregnancy such as preterm birth, fetal distress, malpresentation, maternal illhealth or exhaustion or instrumental delivery, or as a prophylactic procedure during uncomplicated childbirth.

Prophylactic episiotomy has been performed with increasing frequency during this century for several compelling and apparently self-evident reasons, namely that a surgical incision is preferable to a traumatic perineal laceration; that relief of pressure on the fetal head and shortening of the second stage of labour are advantageous; that episiotomy prevents the likelihood of third degree perineal laceration; and that episiotomy prevents perineal damage and consequent genital prolapse. Critical analysis of these reasons, however, reveal certain inconsistencies ([1]). Recently, consumer-based opposition to prophylactic episiotomy has grown ([2]). In a review of the English language literature up to 1980, Thacker & Banta ([3]) found no clearly-defined evidence of the efficacy of episiotomy. In two subsequent prospective randomised control trials ([4, 5]), the value of routine episiotomy has been questioned. Perineal muscle function after childbirth has been found to be related to subsequent exercise and not to the method of delivery or perineal management ([6]).

Resumption of sexual intercourse following childbirth has been reported to occur sooner following a restricted than a liberal episiotomy policy ([4]) and following midline than mediolateral episiotomy ([7]).

Dyspareunia has been suggested to be a short-term complication of episiotomy ([8, 9, 10]). Reading et al (1982) found that of 67 questionnaire respondents who had resumed intercourse 3 months after delivery with episiotomy, 60 (90%) complained of dyspareunia, of whom 88% attributed this discomfort directly to the episiotomy. Many attributed reduction in sexuality to the episiotomy. To our knowledge the longer-term influence of episiotomy on sexual function has not been studied. The aim of this study is to determine whether long-term dyspareunia is related to the perineal management at delivery.

PATIENTS AND METHODS

Information was collected retrospectively by means an anonymous postal questionnaire. Questionnaires were sent to women whose first child had been delivered at the Johannesburg Hospital 12 to 24 months previously. They were grouped according to the method of delivery: Caesarean section; spontaneous vaginal delivery with intact perineum; with second degree perineal laceration; or with episiotomy. Eighty women from each group were matched as clo-

sely as possible for age, marital status and date of delivery. They were all Caucasian and the majority middle to lower middle class.

All episiotomies were of the mediolateral type. The majority of episiotomies and second degree tears had been repaired by senior house officers and senior midwives. Questions covered the presence, severity and localisation of dyspareunia at present, an indication of the degree of dyspareunia on an unmarked, 100 mm analogue scale before the pregnancy, during the pregnancy, and 3 and 12 months after the pregnancy, frequency and enjoyment of sexual intercourse and problems concerning the relationship with the partner.

Statistical analysis was by the Wilcoxon sign ranked test for continuous variables and the four-fold table test ([11]) for proportions.

RESULTS

Of the 320 questionnaires sent out, 62 were returned undelivered because of change of address. The number of completed questionnaires returned was 71, 27.5% of those presumed delivered.

The groups were well matched for age and marital status. Educational status tended to be higher for the groups with second degree perineal laceration and Caesarean section, though the differences did not reach statistical significance. There was no association between educational status and reported dyspareunia.

The responses to questions relating to sexual function are shown in table 1. Of 22 women delivered by Caesarean section, 4 reported dyspareunia which began shortly after giving birth, was mild, and for which no medical advice had been sought. The pain was localised to the «stomach» in three, of which one reported post-operative wound infection and that the pain made sexual intercourse unenjoyable, and one reported relationship problems; the pain was localised in the «vagina» in one patient, who also reported relationship problems. Of 12 women delivered vaginally with intact perineum, one reported dyspareunia localised to the «stomach» which was present before giving birth, and one reported dyspareunia localised to the «vagina» which began shortly after giving birth, was moderate and for which she had sought medical advice. Both reported severe relationship problems but for neither did the dyspareunia make sexual intercourse unenjoyable.

Table 1. — *Questionnaire responses according to method of delivery. Time periods refer to period after childbirth.*

	Caesarean Section	Vaginal delivery		
		Intact	2nd Tear	Episiotomy
Dyspareunia, 1-2 years	4/22 (18%)	2/12 (17%)	0/13 (0%) **	9/24 (38%)
Dyspareunia on analogue scale (%) relative to pre-pregnancy level				
During pregnancy	9.1	1.4	10.4	5
3 months	16 *	9 *	29	35
12 months	4.6	−5.4 **	−0.4 *	17
Frequency of intercourse at 1-2 years, % of pre-pregnancy frequency	81%	86%	89%	65%
Sexual enjoyment at 1-2 years				
Improved	2 (9%)	1 (9%)	1 (8%)	1 (4%)
Impaired	5 (23%)	0	5 (38%)	5 (22%)
Severely impaired	2 (9%)	0	0	4 (17%)
Relationship problems at 1-2 years	3 (14%)	2 (18%)	4 (31%)	10 (43%)

Significance of difference from episiotomy group
* $p<0.05$ ** $p<0.025$

Of 13 women with second degree perineal laceration, three reported perineal wound infection and none dyspareunia at present.

Of 24 women delivered with episiotomy, one reported dyspareunia localised to the vagina which had been present before childbirth, and relationship problems. Eight reported dyspareunia since giving birth, of which one localised the pain to the «stomach», for which she had sought medical advice, and seven localised the pain to the vagina. Of the latter seven, four had sought medical advice for the pain; four reported perineal wound infection, for two with, and for two without infection, the pain made sexual intercourse unenjoyable, and three of the latter four reported relationship problems. Of the women without dyspareunia, five reported having experienced wound infection.

On qualitative assessment dyspareunia 12 to 24 months after delivery was thus significantly more frequent among women delivered with episiotomy than those with second degree perineal laceration.

Quantitative assessment on an analogue scale of dyspareunia, relative to pre-pregnancy values, 3 months after childbirth showed a similar mean value for women with second degree tear and episiotomy. The latter was significantly greater than those with intact perineum or delivered by Caesarean section. By 12 months the value for women with second degree perineal laceration had fallen to the pre-pregnancy level, while that for women with episiotomy was significantly higher than that following spontaneous delivery with intact perineum or perineal laceration.

Decreased frequency of intercourse and severe impairment of sexual enjoyment tended to be more common in the episiotomy group, and relationship problems tended to be more common in the episiotomy and perineal laceration group, but these results were not statistically significant.

DISCUSSION

Our results are consistent with previous finding of considerable dyspareunia 3 months after delivery with episiotomy ([7, 12]). What is of interest is that the similarly high level of dyspareunia reported by our patients 3 months after delivery with second degree perineal laceration had by and large resolved after 12 months, whereas that following episiotomy remained significantly increased.

Compliance with the return of the questionnaire may have selected a study population not representative of the whole. For example, women with problems may have been more or less likely to return the questionnaire. The absolute incidence of problems cannot therefore be generalised to the whole population. However, as any selection bias should operate equally for all groups, the relative differences found between groups are valid.

The small number in each group limits the power of the study to detect small differences between groups. Thus only the large differences achieve statistical significance.

Two interpretations of the results are possible. Either episiotomy causes long-term dyspareunia, or women who are destined to report dyspareunia are more likely to undergo episiotomy than spontaneous perineal laceration. If the latter were true, a consistent excess of dispareunia in the episiotomy group would be expected. The fact that the level of dyspareunia between the episiotomy and perineal laceration groups was similar at 3 months yet significantly different at 12 months suggests that no underlying difference in the tendency to report dyspareunia exists between the groups, but that long-term persistence of dyspareunia is a

specific feature of mediolateral episiotomy and not of perineal laceration.

CONCLUSIONS

Because of the important implications for obstetric practice of the possibility that mediolateral episiotomy may cause long-term dyspareunia, confirmation from larger prospective studies is needed. An ideal population for such a study would be that of the West Berkshire perineal management trial ([4]), if the follow-up concerning genital prolapse promised by the authors were to include an assessment of sexual function.

At present the decision to perform prophylactic mediolateral episiotomy should be influenced by the absence of positive evidence for the value of this procedure, by the attitude of the patient to the procedure, and by the awareness that it may impair sexual function.

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TORSION OF THE ADNEXA

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Summary: The Authors report two cases of adnexal torsion. The first case occurred in a 30-year old patient, while the latter was in a women after induction of ovulation with FSH-LH and hCG. The patient, who had begun a pregnancy was treated with adnexectomy, and delivered at term a normal baby.

Key words: torsion, adnexa, surgery.