Operative vaginal delivery and episiotomy

Author's Reply

Sir,

We thank Murphy *et al.* for their comment on our study.[1,2] Murphy *et al.*[1] state that our results are very different from other studies with underascertainment and underreporting as a possible explanation. They illustrate this with the rate of anal sphincter tears in both vacuum extractions and forceps deliveries. Unfortunately, they state erroneously that these rates were 1.4 and 2.6%, respectively. In our study, an anal sphincter tear occurred in 3.0% of women delivered with vacuum extraction and in 4.7% of women delivered by forceps![2] Furthermore, the statement that the rates mentioned in our study are substantially lower than mostly reported is not corroborated by the studies of Sultan *et al.*[3] and Donnely *et al.*[4] The rate of anal sphincter damage in forceps deliveries in our study is similar to that of anal sphincter tears after forceps delivery (4.2%) in the study of Sultan *et al.*[3] In this study, no sphincter tears were reported in 351 women delivered with vacuum extraction. The study of Donnely *et al.*[4] describes obstetric events in 184 primiparous women only, leading to anal sphincter damage. However, the number of women (22) in this study delivered by forceps or vacuum extraction is too low to draw any conclusions on the rate of anal sphincter tears in operative vaginal delivery. We do underline, however, the statement of Murphy *et al.*[1] that operative vaginal delivery is associated with an increased risk for anal sphincter injury,[5] but this was not the primary aim of this study.

We also agree with Murphy *et al.*[1] that on the basis of our data, obstetricians should abandon the policy of forceps delivery without performing a mediolateral episiotomy, as the anal sphincter rate of almost 23% in these deliveries is unacceptably high.

Our study is a retrospective analysis of deliveries registered in the Dutch National Obstetric Database. We cannot rule out incomplete recording of perineal morbidity. However, in this database, obstetricians are allowed to register per case both episiotomy and any type of perineal damage. The computer system had no default setting of recording only the most serious morbidity. In our opinion, it is therefore unlikely that our results are flawed by incomplete or erroneous recording.

Until a well-performed randomised controlled trial evaluates the role of mediolateral episiotomy in operative vaginal deliveries, retrospective studies in large populations are the best evidence on this subject. Therefore, we await impatiently the results of the randomised trial mentioned by Murphy *et al.*[1] ■

References

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