Episiotomy is obsolete: cinnamon gel applied after episiotomy endangers lives

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Episiotomy is a protocol that became obsolete in 1983[1]. When randomized, controlled studies of episiotomy were carried out, episiotomy was found to be associated with more third-degree extensions, more anal muscle damage, more short- and long-term fecal incontinence, more bleeding, more pain, more short- and long-term sexual discomfort and more sexual dissatisfaction[1]. Most fecal incontinence is a result of damage caused by an episiotomy[2]. Minimizing perineal damage on first vaginal births is critical to the perineal outcomes of subsequent births because the biggest risk factor for perineal damage on subsequent births is a previous episiotomy: 55% of women who had previously had an episiotomy needed to be sutured at subsequent births[3]. A previous third-degree extension of an episiotomy frequently results in a third-degree tear on subsequent births. Between 1940–1990, in most high-income countries, 100% of women having their first child vaginally, in a hospital, underwent episiotomy. This trend continued until there was overwhelming evidence demonstrating that episiotomy resulted in worse outcomes than the alternative. The reason episiotomy was adopted as a common protocol may have been partly due to the lack of data describing the baseline rate of primiparous tears. In 2006, the first study documenting tear rates among primiparous women giving vaginal births without episiotomy, to babies weighing 3 500 g on average, found that 65% of women had no tearing, 33% had first- or second-degree tears sutured, 1% had third-degree tears, and 0.7% had fourth-degree tears. These women all gave birth in hospitals, where 44% had a pitocin infusion, 45% had epidurals and 26% used directed pushing[4]. Thirty-five percent of the women had gained more than 40 pounds during pregnancy. Despite the large babies, the high rate of technological intervention and the location of the births outside of the home, 66% of primiparous women were found to need no suturing at all. The conclusion of the study was that the best way to prevent perineal damage is to avoid episiotomy, as well as push the baby’s head out slowly, preferably between contractions. Rates of 99% suture-free first births have been documented (average birth weight 3 150 g) in the absence of episiotomy, with only 1% need to be sutured[5]. With a motivated attendant, and by eliminating episiotomy, almost all women can deliver vaginally without suturing.

“There is limited data to support the common indications for episiotomy”, according to 2006 Practice Bulletin published by The American College of Obstetricians and Gynecologists (ACOG), therefore ACOG recommends practitioners base their decision on ‘expert opinion’[6]. Episiotomy is not indicated until the head is crowning, at which point the perineum skin can be pushed back past the head with one’s fingers if it refuses to stretch. In the event of a history of a previous third- or fourth-degree tear, episiotomy does not prevent recurrent third- or fourth-degree extensions[3]. In the event of serious fetal distress, an emergency cesarean is indicated, since it is the pelvic bones, not the perineum that is delaying delivery. Episiotomy does not improve outcomes of complicated vaginal delivery, such as shoulder dystocia, breech, forceps or vacuum deliveries[7]. There is no logic to perform episiotomy in the event of maternal stress due to exhaustion because episiotomy will result in more bleeding in an already weak individual and

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will only save a few minutes of effort on the part of the woman. When the baby is about to deliver, encouragement and reminding her that a few minutes of extra work will prevent long-term pain, motivates her to push the baby out.

In a recent study recommending the use of cinnamon gel after episiotomy\(^9\), the authors tested a cinnamon gel and a placebo gel on the episiotomy site. A meaningful study design would have included 4 groups: gel, placebo gel, no gel, and no episiotomy. However, the authors only had 2 groups, both of whom underwent episiotomy and also used a gel. The authors claimed it was a blinded study because both placebo gel and cinnamon gel “were identical in color, shape and size”. But the authors neglect to mention smell. If the placebo no longer had any smell, it is not clear if it still had active ingredient capable of improving healing. If it had smell, then it was not a blinded experiment. The small difference in outcomes could be explained by the women knowing they had the cinnamon gel.

Each study participant received prophylactic cephalexin 500 mg orally 4 times per day for 6 d after birth. Despite this, 0.7% (1/144) of the women using cinnamon gel and 3.5% (5/144) of the women using placebo gel experienced wound dehiscence. Dehiscence of perineal wounds is rare. In the third world environment, where antibiotics are not available, wound dehiscence was found in 0.2% (1/458) of perineal wounds\(^9\). Among high-income countries it is very rare, occurring in 0.002%\(^9\). Dehiscence is an infection so extensive that the stitches come out and the cut takes weeks to close. It is an agonizing process that can also be dangerous. Eight papers document case studies in which women died of postpartum necrotizing fasciitis from perineal wounds\(^9\). Cinnamon gel or placebo gel, increase the risk of wound infection despite the use of routine antibiotics, and therefore is potentially deadly.

Since the average birth weight was a reasonable 3 230 g, if episiotomy had not been cut, and the women were encouraged to deliver slowly between contractions once the head was crowning, 99% of these women could have had no need for suturing at all, and their outcomes would have been much better than they proved to be using episiotomy followed by cinnamon gel or placebo gel.

### Competing interests

The author declares there is no competing interest.

### REFERENCES