fortune Journals

Research Article

OBSTETRICS AND GYNECOLOGY RESEARCH

ISSN: 2637-4560



Maternal Outcome of Spontaneous Vaginal Delivery in Term Pregnancy with Episiotomy and Without Episiotomy

Dr. Roksana Akter[1], Dr. Sharmin Rahman[2], Dr. Syeda Farah Ferdous[3], Dr. Dilruba Ferdous[4], Dr. Sumaiya Tazin[5], Dr. Nasrin Rosy[6], Dr. Mst Jesmin Akter[7]

Abstract

Background: The practice of obstetric care was more sophisticated and improved in the last decades because of emerging technologies and highly trained obstetricians and other care providers. The episiotomy is a technique originally designed to reduce the incidence of severe perineal laceration during labor. The general idea is to make a planned incision in the perineum for enlargement of the vaginal orifice to facilitate difficult deliveries. Adverse effects of routine use of episiotomy include: accidental injury of anal sphincter or rectum by unavoidable extension of the incision, recto-vaginal fistula and fistula in ano etc. Therefore, to see the fruitful outcome of spontaneous vaginal delivery, it is needed to justify the use episiotomy.

Aim of the study: The purpose of the study is to compare between the maternal outcome of spontaneous vaginal delivery at term with episiotomy and without episiotomy.

Methods: A hospital based observational analytical study carried out in the department of Obstetrics and Gynaecology, Dhaka Medical College and Hospital. Sample was selected by purposive sampling. Total 100 samples were taken in this study and allocated in to two groups- Group A and Group B. Group-A subjects were given episiotomy and Group-B women were not given episiotomy. Maternal outcomes were evaluated and compared. Data were collected from the patients and recorded in structured case report form. Clinical examinations were done meticulously. All collected questionnaire checked very carefully to identify the error in the data. Data was processed and analyzed with the help of computer program SPSS (v 30) and Microsoft excel. Quantitative data expressed as mean and standard deviation and qualitative data as frequency and percentage. Comparison was done by tabulation and graphical presentation in the form of tables, graphs, bar diagrams & charts etc.

Result: Mean age was found 26.9±8.3 years in Group-A and 25.4±7.8 years in Group-B. Among the patients the middle class (58.0%) comprising the major percentage of the patients, 60.0% in group A & 56.0% in group B patients. It was observed that maximum e.g 48 patients were housewives, 50.0% in group A and 46.0% in group B. Mean period of gestation was 37.3+0.8 weeks and 38.1+0.5 weeks in group A and in group B respectively. All the demographic characteristics was statistically non-significant ($p>0.05$) between two group. Duration of 2nd stage of labour was prolonged in group-B (32.1±4.5 min) than group-A (29.8±3.7 min). The difference was statistically significant. On comparison between groups, perineal outcome shows that third degree perineal tear was lower in group-B (4.0%) than group-A (8.0%). But differences were statistically non-significant in between groups. Perineal pain

Affiliation:

[1]Medical Officer, Model Family Planning Clinic, Dhaka Medical College Hospital, Dhaka, Bangladesh.

[2]Assistant Professor, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh.

[3]Medical Officer, Dhaka Medical College Hospital, Dhaka, Bangladesh.

[4]Sr. Consultant, Dhaka Medical College Hospital, Dhaka, Bangladesh.

[5]Assistant Registrar, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh.

[6]Associate Professor, Department of Obstetrics and Gynaecology, Sir Salimullah Medical College Mitford Hospital, Dhaka, Bangladesh.

[7]Associate Professor, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh

***Corresponding author:**

Dr. Roksana Akter, Medical Officer, Model Family Planning Clinic, Dhaka Medical College Hospital, Dhaka, Bangladesh.

Citation: Roksana Akter, Sharmin Rahman, Syeda Farah Ferdous, Dilruba Ferdous, Sumaiya Tazin, Nasrin Rosy, Mst Jesmin Akter. Maternal Outcome of Spontaneous Vaginal Delivery in Term Pregnancy with Episiotomy and Without Episiotomy. Obstetrics and Gynecology Research. 9 (2026): 114-120.

Received: September 29, 2026
Accepted: October 07, 2026
Published: November 03, 2026

Dr. Akter R, et al., Obstet Gynecol Res 2026
DOI:10.26502/ogr0210

after childbirth was higher in group-A (14.0% in group-B& 36.0% in group-A). The result was statistically significant between groups. Similarly maternal satisfaction was better in group-B (100% in group-B& 88.0% in group-A). The result was statistically significant between groups. Wound infection was found in 4 (8%) in group A. In group B no wound infection was observed.

Conclusion: Present study concluded that vaginal delivery without episiotomy appears to be safe for mother and child. Although duration of 2nd stage was prolonged in group-B (32.1±4.5 min) than group-A (29.8±3.7 min), but it had no impact on overall perinatal outcome. On comparison between groups, perineal tear in the non-episiotomy group was mostly limited to first and second degree tears with a low incidence of severe tear. Blood loss was slightly higher in group B, but it was statistically non-significant.

Keywords: Episiotomy; Spontaneous vaginal delivery; Maternal outcome; Perineal trauma; Term pregnancy

Introduction

Spontaneous vaginal delivery at term has long been considered the preferred outcome of pregnancy. Vaginal delivery is a natural process that usually does not require significant medical intervention. Management guided by current knowledge of the relevant screening tests and normal labor process can greatly increase the probability of an uncomplicated delivery. Routine episiotomy increases morbidity of mother and should be abandoned. Once the foetus has been delivered, active management of the third stage of labor decreases the risk of postpartum hemorrhage [1]. Episiotomy is the most common obstetric surgical procedure performed in the second stage of labour. It requires suturing .Benefits and harms of episiotomy as part of routine management of normal births remains unclear. In some cases it may causes long-term problems. [2]. According to WHO routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth [3]. Episiotomy is a surgically planned incision on perinium and the posterior vaginal wall. It is one of the most commonly practiced obstetric procedures done to enlarge the diameter of the vulval outlet to facilitate the passage for the fetal head and prevent an uncontrolled tear of the perineal tissues in the second stage of labor [4]. There is high frequency of pain, discomfort, dyspareunia and failure to resume pain free intercourse experienced by women who was sustained an episiotomy [5]. The procedure can be indicated when there is a high likelihood of third-degree or fourth-degree perineal tear, soft tissue dystocia, a requirement to accelerate delivery of a compromised fetus, and need to facilitate operative vaginal delivery or a history of female genital mutilation [6]. Episiotomy has been associated with the risk of repeat episiotomy in the subsequent birth due to tighter perineum and weaker scar. Post episiotomy pain is common after delivery, and this may end up in pain at first intercourse especially if it occurs in the first 3 months after delivery. The risk is higher if intercourse occurs within the first 6 weeks after delivery and in some cases, women present with gaping episiotomy wounds following intercourse [7]. The incision substantially increases maternal blood loss, the average depth of posterior perineal injury, risk of anal sphincter damage, improper wound healing, increased amount of pain in the first several postpartum days, and infection [8]. Episiotomy-related morbidity can be measured using the Redness, Echymosis, Edema, Discharge, and Apposition scale (REEDA scale). Higher REEDA scores denote poor healing process or severe trauma to the perineal tissue. The rate of the gaping wound is particularly higher among those done episiotomy compared with spontaneous perineal tear and this can be attributed to the fact that spontaneous perineal tear occurs normally along the natural tissue planes, and it's easier to repair compared with episiotomy [9]. The aim of the study was to compare the maternal outcome of spontaneous vaginal delivery in term pregnancy with episiotomy and without episiotomy.

Methodology & Materials

This prospective observational analytical study was conducted in the Department of Obstetrics and Gynaecology, Dhaka Medical College and Hospital (DMCH), Dhaka, Bangladesh, over a one-year period from 26 July 2024 to 25 June 2025. The study population comprised women with term pregnancies who were admitted to the Department of Obstetrics and Gynaecology with labour pain and were planned for spontaneous vaginal delivery. Eligible participants were enrolled consecutively after fulfilling the predefined inclusion and exclusion criteria. 100 samples were taken in this study and divided into two groups:

Group A (n=50): Women delivered with the aid of episiotomy

Group B (n=50): Women delivered without episiotomy

Inclusion Criteria:

- Women at term pregnancy (on or after 37 weeks 0 days to 42 weeks) with live single fetus
- An adequate pelvis as assessed by clinical pelvimetry
- Live fetus in vertex presentation.
- No contraindications to vaginal delivery

Exclusion Criteria:

- Expected baby weight of >4 kg.
- Morbid obesity.
- Multiple pregnancy.

Citation: Roksana Akter, Sharmin Rahman, Syeda Farah Ferdous, Dilruba Ferdous, Sumaiya Tazin, Nasrin Rosy, Mst Jesmin Akter. Maternal Outcome of Spontaneous Vaginal Delivery in Term Pregnancy with Episiotomy and Without Episiotomy. Obstetrics and Gynecology Research. 9 (2026): 114-120.

Dr. Akter R, et al., Obstet Gynecol Res 2026
DOI:10.26502/ogr0210

Ethical Considerations

The aims and objectives of the study along with its procedure, methods, risks and benefits of this study was explained to the patients in easily understandable local language and then informed consent was taken from the patient or local guardian. It is assured that all information and records would be kept confidential and the procedure will be helpful for both for the physician and the patients in making rational approach of the case management. Ethical clearance was taken from the local Ethical Committee to perform investigation.

Operational Definitions

Episiotomy: An episiotomy is a surgically planned incision on the perineum and posterior vaginal wall during the second stage of labour.

Spontaneous tears are defined as [10]:

- First degree (involving the fourchette, perineal skin and vaginal mucous membrane, but not the underlying fascia and muscle);
- Second degree (involving the perineal muscles and skin);
- Third degree (injury to the anal sphincter complex: 3a = < 50% of the external anal sphincter torn 3b = 50% of the external anal sphincter torn 3c = injury to the external and internal anal sphincter); and
- Fourth degree (injury to the perineum involving the anal sphincter complex and anal epithelium).
- Satisfaction means:A customer satisfaction score(CSAT) is a percentage metric that measures how happy the customers are with the product,service or experience. It is calculated by percentage of positive responses out of total responses,with 75-85% considerd good.

Data Collection

Data were collected prospectively using a structured and pretested Case Record Form (CRF) through face-to-face interviews, clinical examination, and review of medical records. Eligible women were enrolled after obtaining written informed consent at the time of admission and were followed until hospital discharge. Baseline information included socio-demographic characteristics, obstetric history (gravidity, parity, abortion, previous preterm labor, previous obstetric outcomes, birth spacing, and history of intrapartum or postpartum complications), and the current pregnancy history, including the last menstrual period and gestational age. A comprehensive physical examination and relevant clinical investigations were performed for all participants. On admission, fetal well-being was assessed using cardiotocography (CTG), and labor progress was monitored according to the WHO Labour Care Guide. Participants were allocated into two study groups according to the study protocol: women assigned to Group A underwent mediolateral episiotomy during vaginal delivery, whereas episiotomy was avoided in Group B unless clinically indicated. Active management of the third stage of labor was performed in accordance with WHO recommendations.

Maternal and neonatal outcomes were assessed immediately after delivery and throughout the postpartum hospital stay. Information on postpartum complications, including perineal trauma, blood loss, wound infection, perineal pain, and maternal satisfaction, was recorded.

Statistical Analysis

All collected data were coded, entered into a Microsoft Excel spreadsheet. Data were checked for completeness and exported to IBM SPSS Statistics for Windows (V 26.0, IBM Digital Analytics, Armonk, NY, USA). Descriptive statistical analyses were performed for both the groups using proportions expressed as percentages. Chi-squared tests ($\chi 2$) or Fisher's exact tests was used to determine statistically significant differences between categorical variables. Continuous variables were summarized using means and standard deviations. Result was done by tabulation and graphical presentation in the form of tables, graph, and chart.

Result

Most participants were aged 24–29 years (46.0% in Group A vs. 44.0% in Group B), with a mean age of 26.9 ± 8.3 years and 25.4 ± 7.8 years, respectively (p=0.324). Secondary education was the most common level in both groups (38.0% vs. 36.0%). The majority of participants were housewives (50.0% in Group A and 46.0% in Group B). There were no statistically significant differences between the two groups in terms of age distribution (p=0.741), educational level (p=0.317), or occupation (p=0.158) (Table 1). More than half of the participants belonged to the poor socioeconomic class (52.0%), followed by the upper class (28.0%) and the middle class (20.0%) (Figure 1). Term delivery at 37–38 weeks was the most common gestational age in both groups, observed in 84.0% of Group A and 72.0% of Group B. The average gestational age did not differ significantly between the groups (37.3 ± 0.8 vs. 38.1 ± 0.5 weeks; p=0.523) (Table 2). Primigravida women constituted the majority in both groups, accounting for 71.0% in Group A and 62.0% in Group B (Figure 2). The second stage of labor lasted ≤1 hour in most participants (92.0% in Group A vs. 86.0% in Group B). The mean duration was significantly shorter in Group A than in Group B (29.8 ± 3.7 vs. 32.1 ± 4.5 minutes; p=0.006) (Table 3). Among women in the non-episiotomy group, 40.0% experienced a first-degree perineal tear, 34.0% had a second-degree tear, and 4.0% sustained a third-degree tear, while 22.0% had no perineal tear (Table 4). Most women in both groups had postpartum blood loss of ≤500 mL (92.0%

Dr. Akter R, et al., Obstet Gynecol Res 2026
DOI:10.26502/ogr0210

in Group A vs. 86.0% in Group B). The mean blood loss was 268.9 ± 48.2 mL in Group A and 285.3 ± 36.7 mL in Group B, with no statistically significant difference between the groups (p=0.058) (Table 5). Postpartum wound infection was uncommon, occurring in 6.0% of women in Group A and in none of the women in Group B, with no statistically significant difference between the groups (p=0.081). Perineal pain after childbirth was reported significantly more often in Group A than in Group B (36.0% vs. 14.0%; p=0.011). Maternal satisfaction, assessed using the CAST score, was significantly higher in Group B, where all participants (100.0%) were satisfied compared with 88.0% in Group A (p=0.011) (Table 6).

Table 1: Sociodemographic characteristics of the study participants (N=100)

Variable	Group A (n=50)		Group B (n=50)		p-value
	n	%	n	%	
Age group (years)					
18–23	14	28	17	34	0.741
24–29	23	46	22	44	
30–35	13	26	11	22	
Mean ± SD	26.9 ± 8.3		25.4 ± 7.8		0.324
Educational level					
Illiterate	4	8	3	6	0.317
Primary	17	34	20	40	
Secondary	19	38	18	36	
Higher secondary or above	10	20	9	18	
Occupation					
Housewife	25	50	23	46	0.158
Service	14	28	15	30	
Daily worker	11	22	12	24	

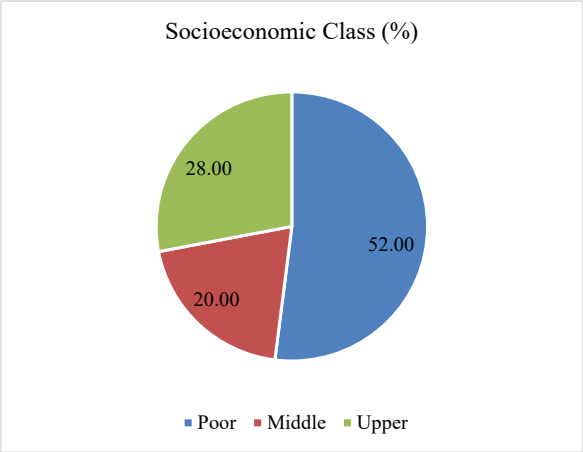


Figure 1: Socioeconomic status of the respondents (N=100)

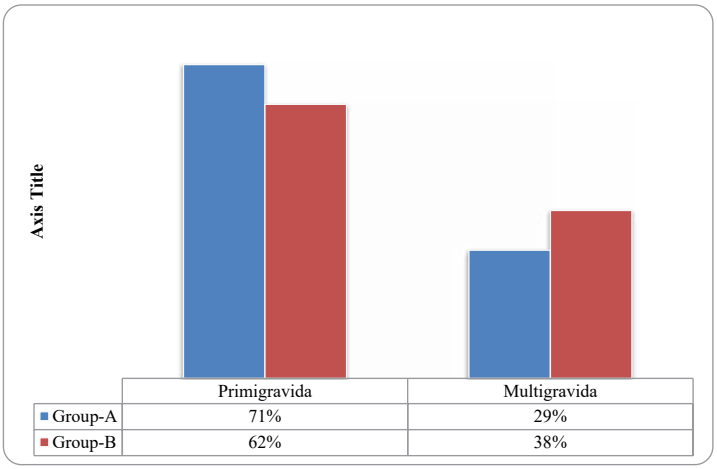


Figure 2: Distribution of participants according to gravidity (N=100)

Table 2: Period of gestation of study participants (N=100)

Gestational age (weeks)	Group A (n=50)		Group B (n=50)		p-value
	n	%	n	%	
37–38	42	84	36	72	0.523
38–39	8	16	9	18	
40–42	0	0	5	10	
Gestational age (weeks), mean ± SD	37.3 ± 0.8		38.1 ± 0.5		

Citation: Roksana Akter, Sharmin Rahman, Syeda Farah Ferdous, Dilruba Ferdous, Sumaiya Tazin, Nasrin Rosy, Mst Jesmin Akter. Maternal Outcome of Spontaneous Vaginal Delivery in Term Pregnancy with Episiotomy and Without Episiotomy. Obstetrics and Gynecology Research. 9 (2026): 114-120.

Dr. Akter R, et al., Obstet Gynecol Res 2026
DOI:10.26502/ogr0210

Table 3: Intrapartum characteristics of study population (N=100)

Duration of 2nd stage	Group A (n=50)		Group B (n=50)		p-value
	n	%	n	%	
>1 hour	4	8	7	14	0.006
≤1 hour	46	92	43	86	
Mean ± SD, (minutes)	29.8 ± 3.7		32.1 ± 4.5		

Table 4: Outcome of respondents of group B (non episiotomy, n=50)

Perineal outcome	Frequency (n)	Percentage (%)
No tear	11	22
First-degree tear	20	40
Second-degree tear	17	34
Third-degree tear	2	4

Table 5: Assessment of postpartum blood loss at delivery (N=100)

Postpartum blood loss	Group A (n=50)		Group B (n=50)		p-value
	n	%	n	%	
>500 ml	4	8	7	14	0.058
≤500 ml	46	92	43	86	
Mean ± SD (min)	268.9±48.2		285.3±36.7		

Table 6: Post-partum outcome of the respondents (N=100)

Post-partum outcome	Group A (n=50)		Group B (n=50)		p-value
	n	%	n	%	
Wound infection					
Yes	3	6	0	0	0.081
No	47	94	50	100	
Perineal pain after childbirth					
Yes	18	36	7	14	0.011
No	32	64	43	86	
Maternal satisfaction (according to CAST score)					
Satisfied	44	88	50	100	0.011
Dissatisfied	6	12	0	0	

Discussion

This study was conducted in of Obstetrics & Gynecology ward of Dhaka Medical College Hospital, Dhaka, to compare the maternal outcome of spontaneous vaginal delivery in term pregnancy with episiotomy and without episiotomy. In this study, age ranging from 18 to 35 years. It was observed that majority of patients belonged to age 24-29 years. The mean age was found 26.9±8.3 years in Group-A and 25.4±7.8 years in Group-B. Among the patients the poor class (52.0%) comprising the major percentage of the patients, 60.0% in group A & 56.0% in group B. It was observed that maximum respondents were housewives, 50.0% in group A and 46.0% in group B. Mean period of gestation was 37.3+0.8 weeks and 38.1+0.5 weeks in group A and in group B respectively. Maximum respondents were primi-gravida (70.0% in group A and 62.0% in group B). Multigravida respondents were 30.0% in group A and 38.0% in group B. All the demographic characteristics were statistically non-significant (p>0.05) between two group. Findings consistent with results of other previous studies. In a study the baseline characteristics of the women in the two groups were similar. Mean age was 23 years. The percentage of primiparous women was 59.9%, with no statistically significant difference between the groups. Median gestational age at delivery was 39 weeks in both groups [11]. In this study duration of 2nd stage of labour

Dr. Akter R, et al., Obstet Gynecol Res 2026
DOI:10.26502/ogr0210

was prolonged in group-B (32.1±4.5 min) than group-A (29.8±3.7 min). The difference was statistically non-significant. Postpartum haemorrhage was slightly higher in group B (7.0%) than group A (4.0%). The difference between groups was statistically non-significant. On comparison of perineal outcomes between groups, pineal tear in group B mostly limited to first and second degree with a low incidence of severe or third degree tear(4% in group B and 8% in group A). This suggests that non episiotomy management may be associated with acceptable levels of perineal injury. In one study that included 168,077 vaginal births at the University of Soroka Medical Centre, Israel, mediolateral episiotomy was found to be an independent risk factor for third and fourth degree perineal lacerations, even in critical situations such as shoulder dystocia, instrumental deliveries, posterior presentations, fetal macrosomia and non-reassuring fetal heart rate. The episiotomy rates at that hospital fell from over 30% in the 1990s to less than 5% in 2010 [12]. Using a non-episiotomy protocol associated with strategies aimed at protecting the perineum, Amorim et al. reported an intact perineum rate of approximately 60%, with only 23% of women requiring perineal suturing [6,13]. That study, however, was not controlled and which was conducted with a specific sample of women and the authors recommended that randomized clinical trials should be performed to compare a non-episiotomy policy with one of selective episiotomy. In this study, perineal pain after childbirth was significantly lower in group B which may contribute to improved maternal comfort and recovery. In addition, maternal satisfaction was higher in group-B indicating better overall childbirth experience without episiotomy. Wound infection was found only in group A. In group B no wound infection was observed. The difference was not statistically significant due to small sample size. Previous study reported that secondary maternal outcomes show no significant difference between groups. The frequency of postpartum perineal pain was similar, around 50%, in both groups. There were no cases of dehiscence, hematoma or wound infection in either of the groups. Around 99% of the women in the non-episiotomy group were satisfied or very satisfied compared to 96% in the selective episiotomy group, with no significant difference between the groups [11]. Episiotomy was introduced into obstetric practice without any scientific evidence. Its use became widespread in the twentieth century based on the recommendation of renowned obstetricians such as Gabbe and De Lee [14]. The paradigm that existed at that time was interventionist to the extreme in that the female body was believed to be essentially defective and dependent on medical interventions to enable childbirth to take place [15]. This belief, together with a change in the place of childbirth, away from the home and into the hospital environment, contributed to the popularization of the procedure in hospitals. It was only in the 1970s that discordant voices began to be heard, generally from within women's movements, demanding changes in the obstetric model [16]. In 1984, the results of the first randomized clinical trial on the subject were published. That study, conducted in the United Kingdom, reported an episiotomy rate of 10% when the proposal was to perform the procedure selectively [17]. Various other randomized clinical trials followed and are summarized in a Cochrane systematic review. The well-documented advantages of restricting the practice of episiotomy rather than encouraging its routine use include less risk of posterior perineal trauma and of severe perineal trauma. Other positive consequences are less blood loss, less need for sutures, a lower frequency of postpartum perineal pain, a lower risk of perineal suture complications (oedema, dehiscence, infection and hematoma), fewer cases of postpartum loss of perineal muscle strength and less risk of dyspareunia [18]. Furthermore, routine episiotomy is now considered a form of obstetric violence, particularly when performed without informed consent. A relatively new legal term, "obstetric violence" is used to describe a situation in which any form of labor in childbirth is considered pathological, when a woman is automatically transformed into a patient and when routine medical and pharmacological procedures are carried out without giving the woman the right to make her own decisions with respect to her own body [19]. Routinely performing procedures that, in addition to being unnecessary, may be harmful, characterizes mistreatment during childbirth [20]. In this context, routine or high rates of episiotomy can be categorized as female genital mutilation [21].

Limitations of the study:

This study was not without limitation. The limitations of the studies were as follows:

- Small sample size of the study population.
- It was a single centre study. Only patients admitted in DMCH were taken for the study. So this will not reflect the overall picture of the country. A large scale study needs to be conducted to reach to a definitive conclusion.
- Study was conducted in a tertiary care hospital where expert hands conducted the deliveries which may not represent primary or secondary centres.
- Sample were taken by purposive method in which question of personal biasness might arise.

Conclusion

This study demonstrates that spontaneous vaginal delivery without episiotomy is associated with comparable maternal safety and improved postpartum outcomes. Although in non- episiotomy group showed a slightly higher proportion of postpartum blood loss, the difference was statistically not significant. Penineal tears in the non-episiotomy group was mostly limited to first and second degree tears, with a low incidence of severe tears .Importantly women who did not

undergo episiotomy experienced significantly less perineal pain and reported higher maternal satisfaction. In conclusion, vaginal delivery without episiotomy improves maternal comfort and satisfaction without increasing significant adverse outcomes.

Recommendations

Episiotomy should be restricted to use in situations in which it is clearly indicated, and should not be routinely used during normal vaginal delivery.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee.

References

1. Patterson DA, Winslow M, Matus CD. Spontaneous vaginal delivery. American family physician. 78 (2008): 336-341.
2. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. (2) 2017.
3. World Health Organization. WHO recommendation on episiotomy policy. Geneva: World Health Organization. Available from: https://www.who.int/tools/elena/interventions/episiotomy
4. Borruto F, Comparetto C. Episiotomy: a too often unnecessary and harmful practice. MOJ Womens Health. 2 (2016): 25-26.
5. Nygaard CC, Tsiapakidou S, Pape J, et al. Appraisal of clinical practice guidelines on the management of obstetric perineal lacerations and care using the AGREE II instrument. European Journal of Obstetrics & Gynecology and Reproductive Biology. 247 (2020): 66-72.
6. Amorim MM, Franca-Neto AH, Leal NV, Melo FO, Maia SB, Alves JN. Is it possible to never perform episiotomy during vaginal delivery? Obstetrics & Gynecology. 123 (2014): 38S.
7. Alum AC, Kizza IB, Osingada CP, et al. Factors associated with early resumption of sexual intercourse among postnatal women in Uganda. Reproductive health 12 (2015): 107.
8. Woolley RJ. Benefits and risks of episiotomy: a review of the English-language literature since 1980. Part I. Obstetrical & gynecological survey. 50 (1995): 806-820.
9. Pebolo PF, Judith A, Dan KK. Episiotomy related morbidities measured using redness, edema, ecchymosis, discharge and apposition scale and numerical pain scale among primiparous women in Mulago National Referral Hospital, Kampala, Uganda. Pan African Medical Journal 36 (2020).
10. Carroli G, Mignini L. Episiotomy for vaginal birth. Cochrane database of systematic reviews. (1) (2009).
11. M. Amorim M, Coutinho IC, Melo I, Katz L. Selective episiotomy vs. implementation of a non-episiotomy protocol: a randomized clinical trial. Reproductive health. 14 (2017): 55.
12. Steiner N, Weintraub AY, Wiznitzer A, Sergienko R, Sheiner E. Episiotomy: the final cut?. Archives of gynecology and obstetrics. 286 (2012): 1369-1373.
13. Leal NV, Amorim MM, Franca-Neto AH, et al. Factors associated with perineal lacerations requiring suture in vaginal births without episiotomy. Obstetrics & Gynecology. 123 (2014): 63S-64S.
14. Gabbe SG, DeLee JB. The prophylactic forceps operation. 1920. American journal of obstetrics and gynecology. 187 (2002): 254.
15. Davis-Floyd R. Birth as an American rite of passage. Routledge; 5 (2022).
16. Myers-Helfgott MG, Helfgott AW. Routine use of episiotomy in modern obstetrics: should it be performed? Obstetrics and gynecology clinics of North America. 26 (1999): 305-325.
17. Sleep J, Grant A, Garcia JO, Elbourne D, et al. West Berkshire perineal management trial. Br Med J (Clin Res Ed). 289 (1984): 587-590.
18. Catling-Paull C, Coddington RL, Foureur MJ, Homer CS. Publicly funded homebirth in Australia: a review of maternal and neonatal outcomes over 6 years. Medical Journal of Australia 198 (2013): 616-620.
19. D'Gregorio RP. Obstetric violence: a new legal term introduced in Venezuela. International Journal of Gynecology & Obstetrics 111 (2010) :201-202.
20. Bohren MA, Vogel JP, Hunter EC, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS medicine. 12 (2015): e1001847.
21. Belizán JM, Miller S, Salaria N. We need to stop female genital mutilation!. Reproductive Health. 13 (2016): 43.

This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC-BY) license 4.0

Citation: Roksana Akter, Sharmin Rahman, Syeda Farah Ferdous, Dilruba Ferdous, Sumaiya Tazin, Nasrin Rosy, Mst Jesmin Akter. Maternal Outcome of Spontaneous Vaginal Delivery in Term Pregnancy with Episiotomy and Without Episiotomy. Obstetrics and Gynecology Research. 9 (2026): 114-120.