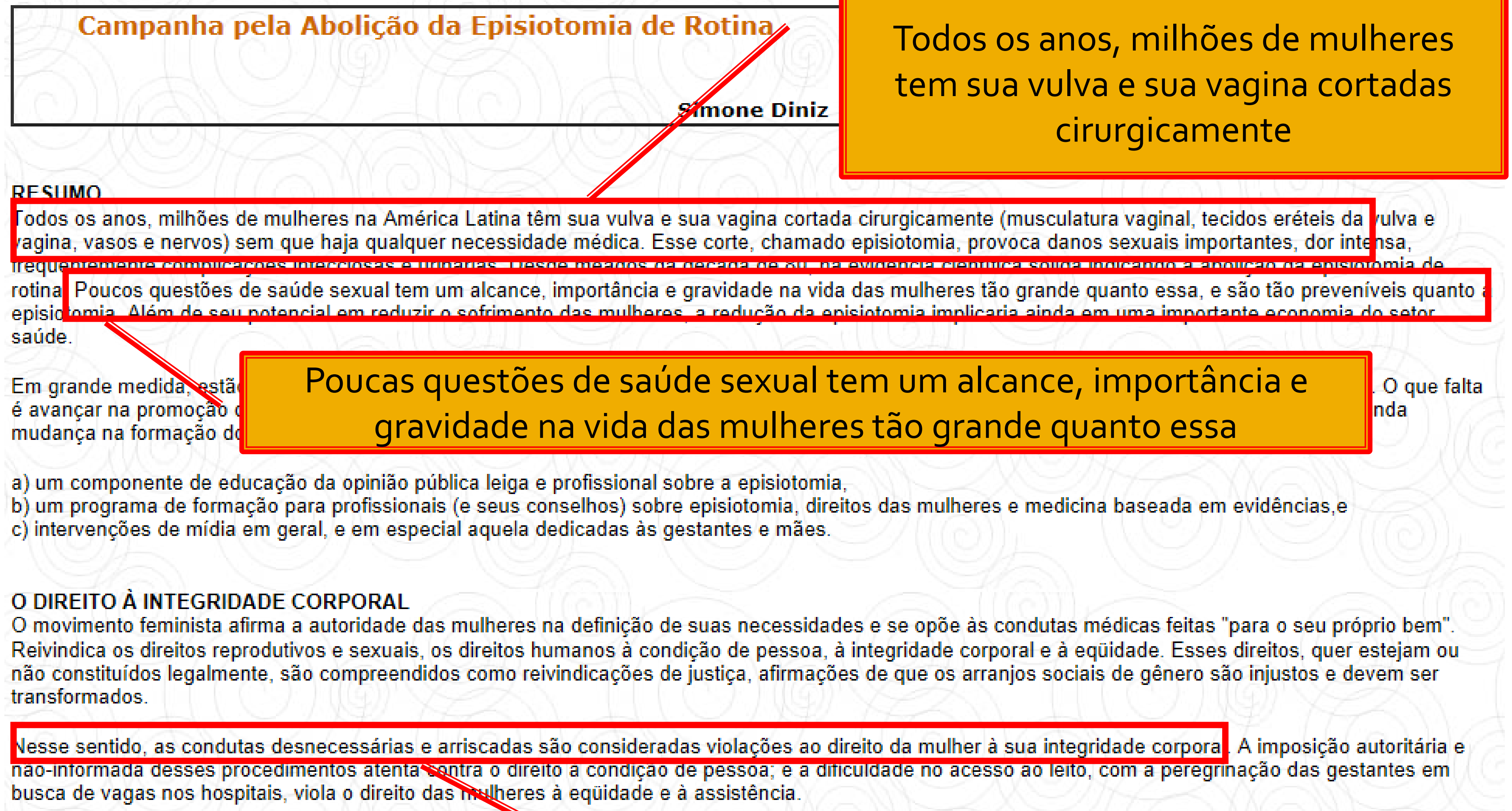
Edson Borges de Souza
Hospital Sofia Feldman, BH

Proteção do períneo no parto vaginal

Curitiba, 07 de Julho de 2015

Porque falar de episiotomia?



Campanha pela Abolição da Episiotomia de Rotina

Simone Diniz

RESUMO

Todos os anos, milhões de mulheres na América Latina têm sua vulva e sua vagina cortada cirurgicamente (musculatura vaginal, tecidos eréteis da vulva e vagina, vasos e nervos) sem que haja qualquer necessidade médica. Esse corte, chamado episiotomia, provoca danos sexuais importantes, dor intensa, frequentemente complicações infecciosas e urinárias. Desde meados da década de 80, há evidência científica sólida indicando a abolição da episiotomia de rotina. Poucos questões de saúde sexual tem um alcance, importância e gravidade na vida das mulheres tão grande quanto essa, e são tão preveníveis quanto a episiotomia. Além de seu potencial em reduzir o sofrimento das mulheres, a redução da episiotomia implicaria ainda em uma importante economia do setor saúde.

Em grande medida, estã . O que falta
é avançar na promoção d nda
mudança na formação d

a) um componente de educação da opinião pública leiga e profissional sobre a episiotomia,
b) um programa de formação para profissionais (e seus conselhos) sobre episiotomia, direitos das mulheres e medicina baseada em evidências,e
c) intervenções de mídia em geral, e em especial aquela dedicadas às gestantes e mães.

O DIREITO À INTEGRIDADE CORPORAL

O movimento feminista afirma a autoridade das mulheres na definição de suas necessidades e se opõe às condutas médicas feitas "para o seu próprio bem". Reivindica os direitos reprodutivos e sexuais, os direitos humanos à condição de pessoa, à integridade corporal e à eqüidade. Esses direitos, quer estejam ou não constituídos legalmente, são compreendidos como reivindicações de justiça, afirmações de que os arranjos sociais de gênero são injustos e devem ser transformados.

Nesse sentido, as condutas desnecessárias e arriscadas são consideradas violações ao direito da mulher à sua integridade corporal. A imposição autoritária e não-informada desses procedimentos atenta contra o direito à condição de pessoa; e a dificuldade no acesso ao leito, com a peregrinação das gestantes em busca de vagas nos hospitais, viola o direito das mulheres à eqüidade e à assistência.

Todos os anos, milhões de mulheres tem sua vulva e sua vagina cortadas cirurgicamente

Poucas questões de saúde sexual tem um alcance, importância e gravidade na vida das mulheres tão grande quanto essa

Campanha pela Abolição
da Episiotomia
de Rotina

Episiotomia de Rotina:
EnXota da tua Vida!!!
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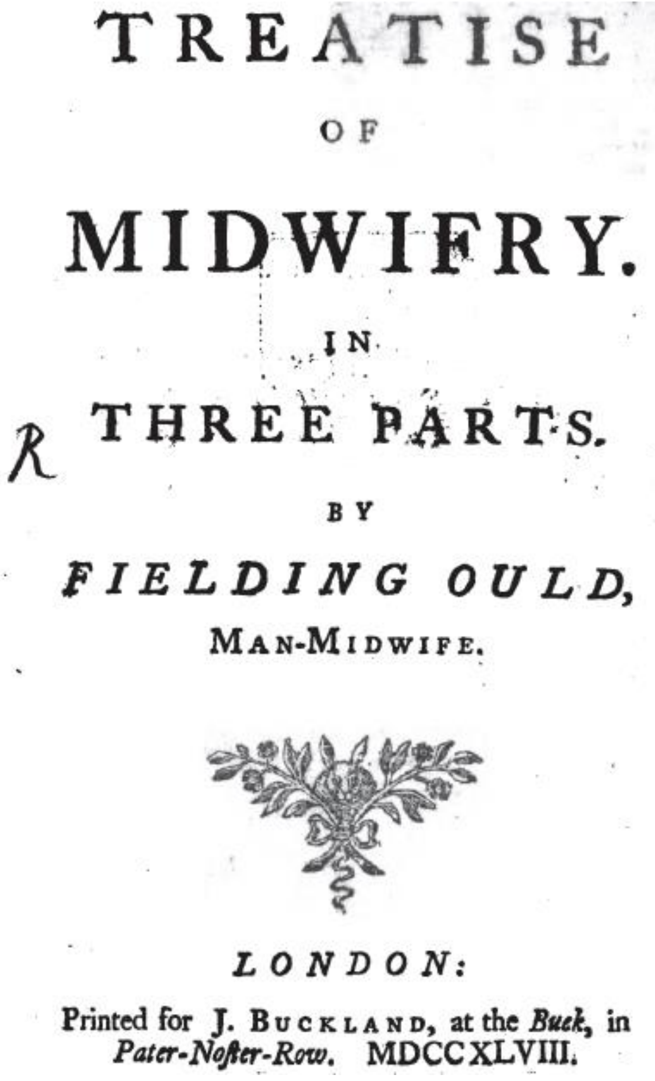
Nesse sentido, as condutas desnecessárias e arriscada são consideradas violações ao direito da mulher à sua integridade corporal.

Breve histórico da episiotomia



A TREATISE OF MIDWIFRY. IN THREE PARTS.

BY

FIELDING OULD,

MAN-MIDWIFE.

LONDON:

Printed for J. BUCKLAND, at the *Buck*, in
Pater-Noſter-Row. MDCCXLVIII.

r ſometimes happens, though the La-
has ſucceeded ſo well, that the Head of
Child has made its Way through the
es of the Pelvis, that it cannot however
e forward, by Reaſon of the extraordinary Conſtriction of the external Orifice of the Vagina; ſo that the Head, after it has paſſed the Bones, thruſts the Fleſh and Integuments before it, as if it were contained in a Purſe; in which Condition if it continues long, the Labour will become dangerous, by the Orifice of the Womb contracting about the Child's Neck; wherefore it muſt be dilated if poſſible by the Fingers, and forced over the Child's Head; if this cannot be accompliſhed, there muſt be an Inciſion made towards the Anus with a Pair of crook-

"Algumas vezes acontece que, embora o trabalho de parto tenha evoluído bem, que a cabeça fetal tenha progredido através dos ossos pélvico, mas não progride adiante, devido à extraordinária constrição do orifício externo da vagina. Nesta condição, o trabalho de parto pode se tornar perigoso; (...) se possível a vagina pode ser dilatada com os dedos, e pressionada contra a cabeça da criança; se isso não é possível, deve-se fazer uma incisão em direção ao ânus com uma tesoura"

THE PROPHYLACTIC FORCEPS OPERATION, 1920

TIME
The Weekly Newsmagazine
Volume XXVII
CHICAGO'S DR. JOSEPH DE LEE
Number 21

Algumas vezes, durante o parto, a fascia rasga e se distende mais do que desejamos, mas nunca tanto que percamos a vantagem das incisões preliminaries.

Através da extração lenta, reduzimos muito essa possibiidade. O reparo é feito com catgut, camada por camada: vagina, músculo, fáscia, septo urogenital, subcutâneo, e pele, tudo de maneira anatômico-cirúrgica.

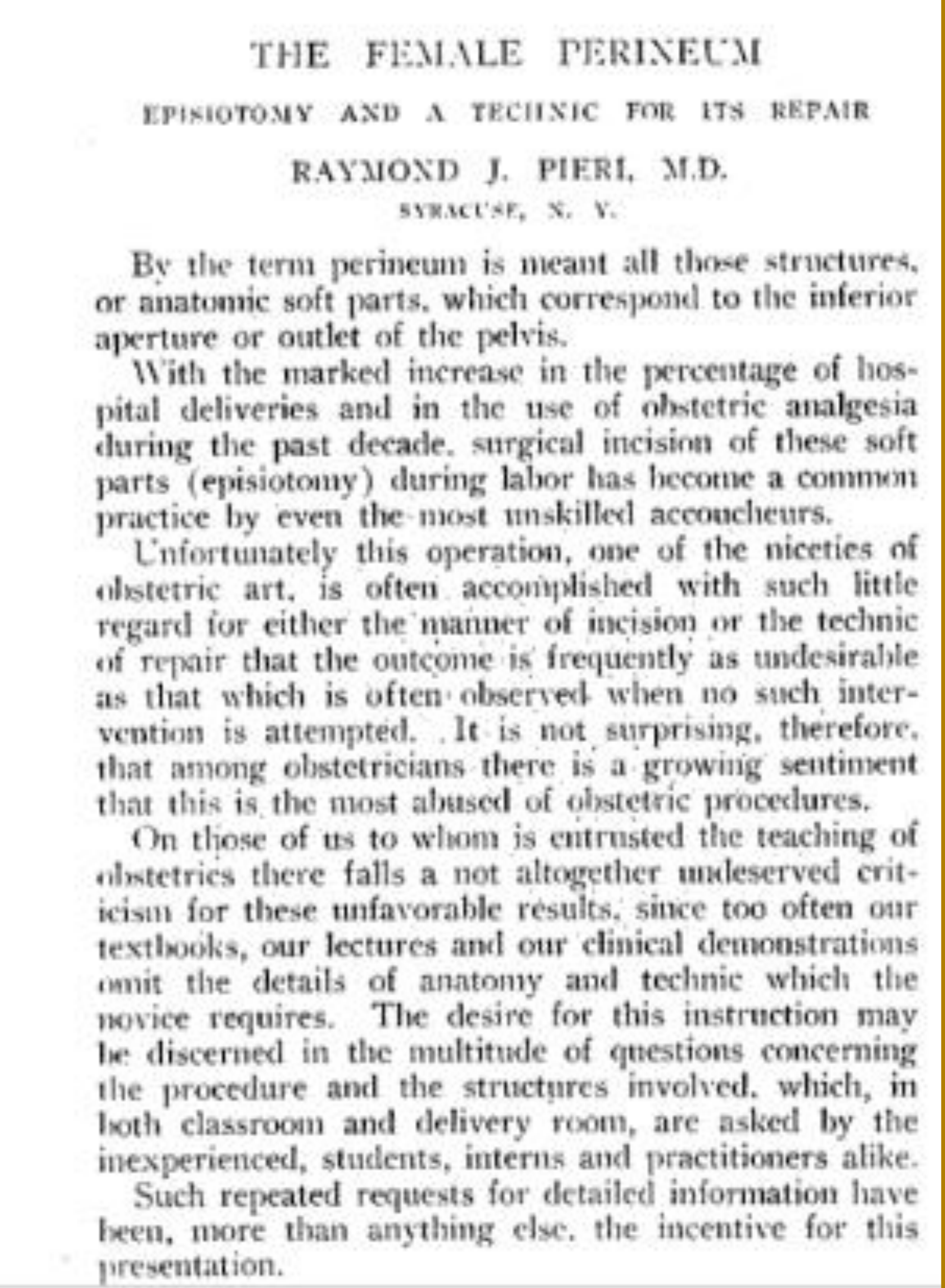
A união primária é a norma e exames posteriores mostram que as condições virginais usualmente são restabelecidas.

O parto como patologia

- Tão frequentes são os maus resultados, que frequentemente me pergunto se a natureza não intencionou deliberadamente que as mulheres fossem usadas, no momento da reprodução, de maneira análoga à de um salmão: que morre após a reprodução?

- ...mas se você acredita que uma mulher após o parto deva ser tão saudável, e tão anatomicamente perfeita quanto antes, e que o bebê deva estar íntegro, então deverá concordar comigo que **o parto é uma patologia porque a experiência prova que estes resultados ideais são raros**.

THE PROPHYLACTIC FORCEPS OPERATION, 1920



THE FEMALE PERINEUM

EPISIOTOMY AND A TECHNIC FOR ITS REPAIR

RAYMOND J. PIERI, M.D.
SYRACUSE, N. Y.

By the term perineum is meant all those structures, or anatomic soft parts, which correspond to the inferior aperture or outlet of the pelvis.

With the marked increase in the percentage of hospital deliveries and in the use of obstetric analgesia during the past decade, surgical incision of these soft parts (episiotomy) during labor has become a common practice by even the most unskilled accoucheurs.

Unfortunately this operation, one of the niceties of obstetric art, is often accomplished with such little regard for either the manner of incision or the technic of repair that the outcome is frequently as undesirable as that which is often observed when no such intervention is attempted. It is not surprising, therefore, that among obstetricians there is a growing sentiment that this is the most abused of obstetric procedures.

On those of us to whom is entrusted the teaching of obstetrics there falls a not altogether undeserved criticism for these unfavorable results, since too often our textbooks, our lectures and our clinical demonstrations omit the details of anatomy and technic which the novice requires. The desire for this instruction may be discerned in the multitude of questions concerning the procedure and the structures involved, which, in both classroom and delivery room, are asked by the inexperienced, students, interns and practitioners alike. Such repeated requests for detailed information have been, more than anything else, the incentive for this presentation.

“Com o aumento acentuado no número de partos hospitalares e no uso da analgesia obstétrica durante a última década, a incisão cirúrgica dessas partes moles (episiotomia) durante o trabalho de parto tornou-se uma prática comum”

“Infelizmente, essa operação, uma das “belezas” (niceties) da arte obstétrica, frequentemente é realizada sem cuidado com a incisão e o reparo, de forma que os resultados frequentemente são tão indesejáveis quanto aqueles observados quando não se realiza esta intervenção”

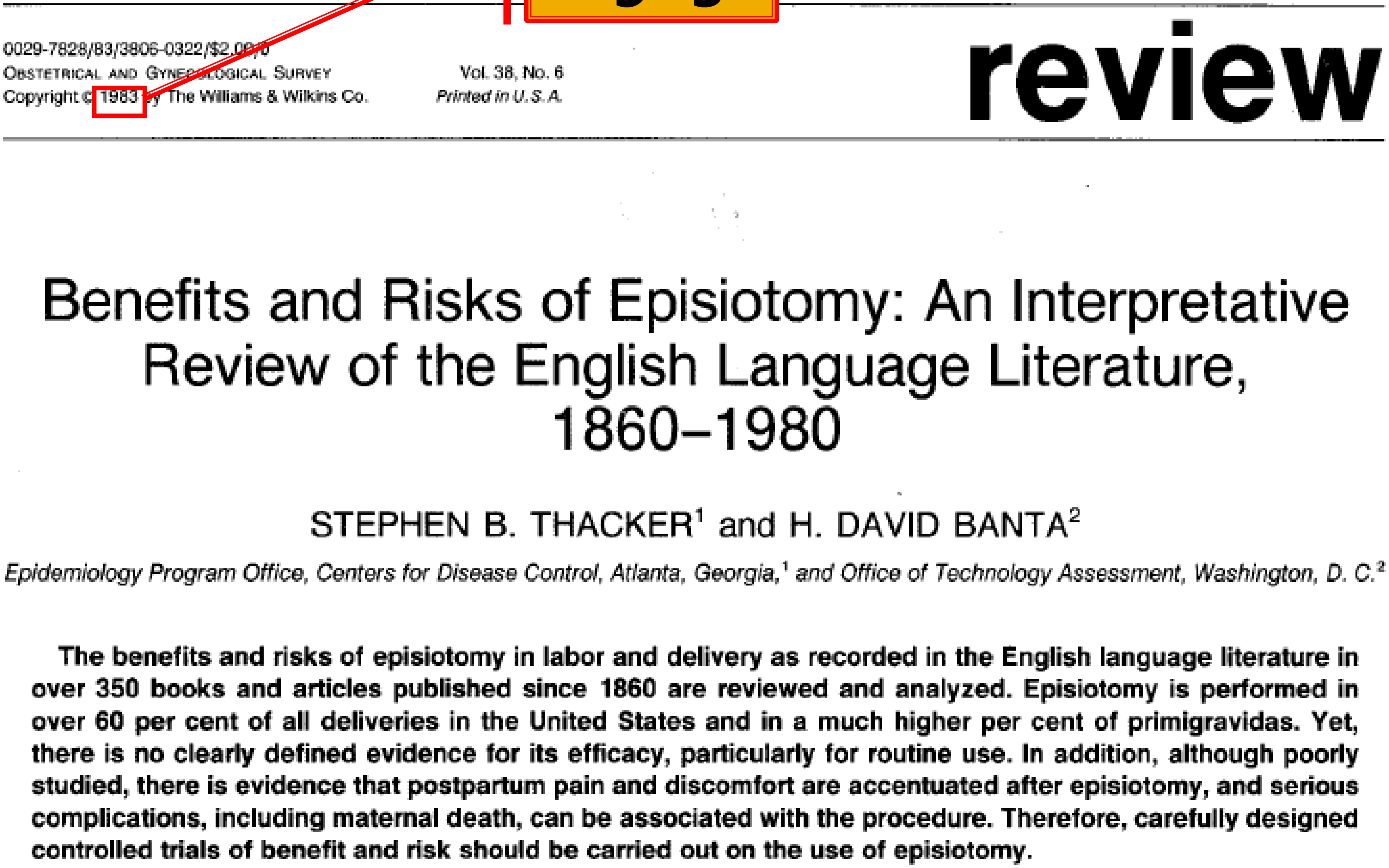
“Não surpreende, então, que entre os obstetras exista um sentimento crescente de que este seja um dos procedimentos obstétricos mais abusados”

JAMA, 1938

Benefícios esperados

Riscos conhecidos

1983



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review

Benefits and Risks of Episiotomy: An Interpretative Review of the English Language Literature, 1860–1980

STEPHEN B. THACKER[1] and H. DAVID BANTA[2]

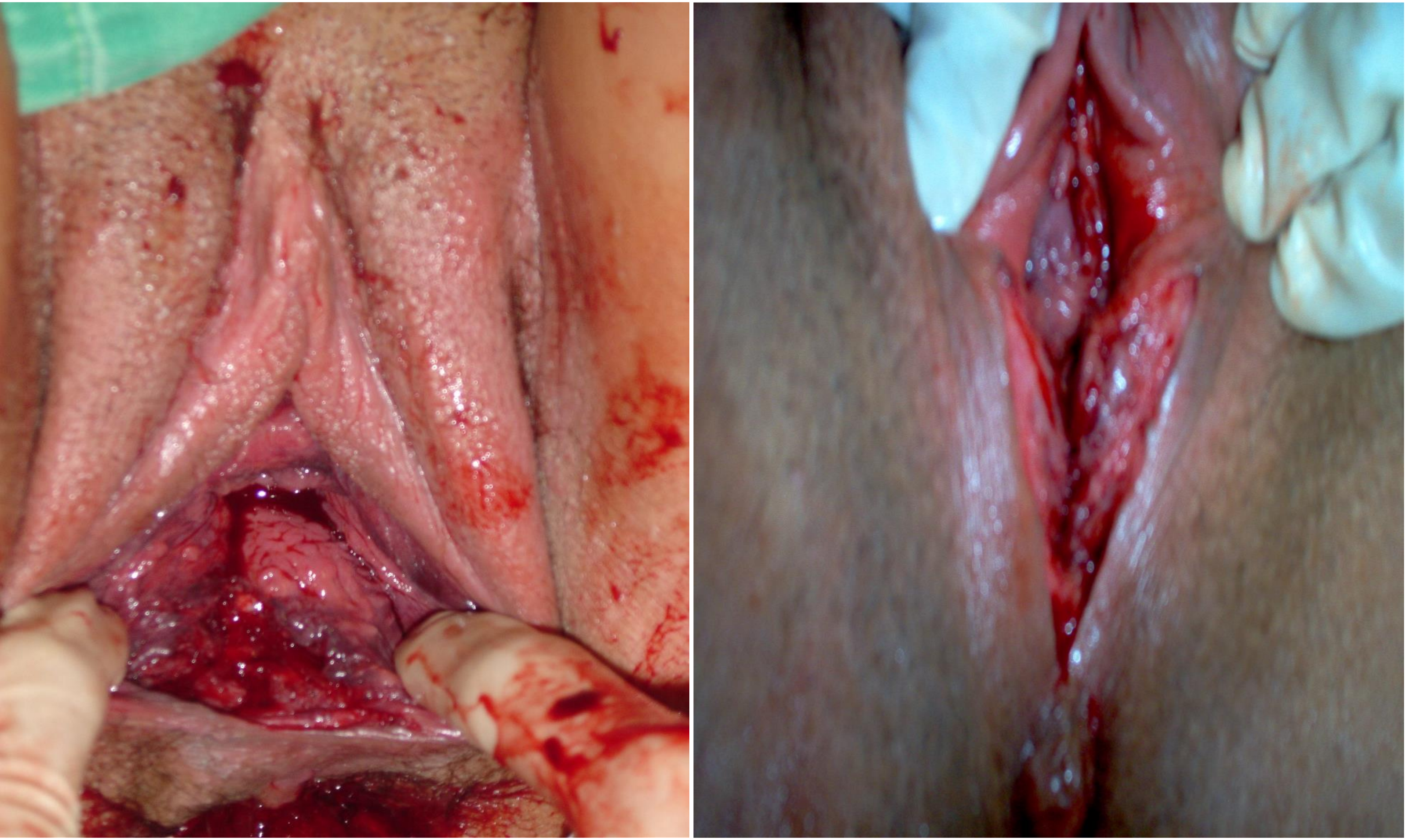
Epidemiology Program Office, Centers for Disease Control, Atlanta, Georgia,[1] and Office of Technology Assessment, Washington, D. C.[2]

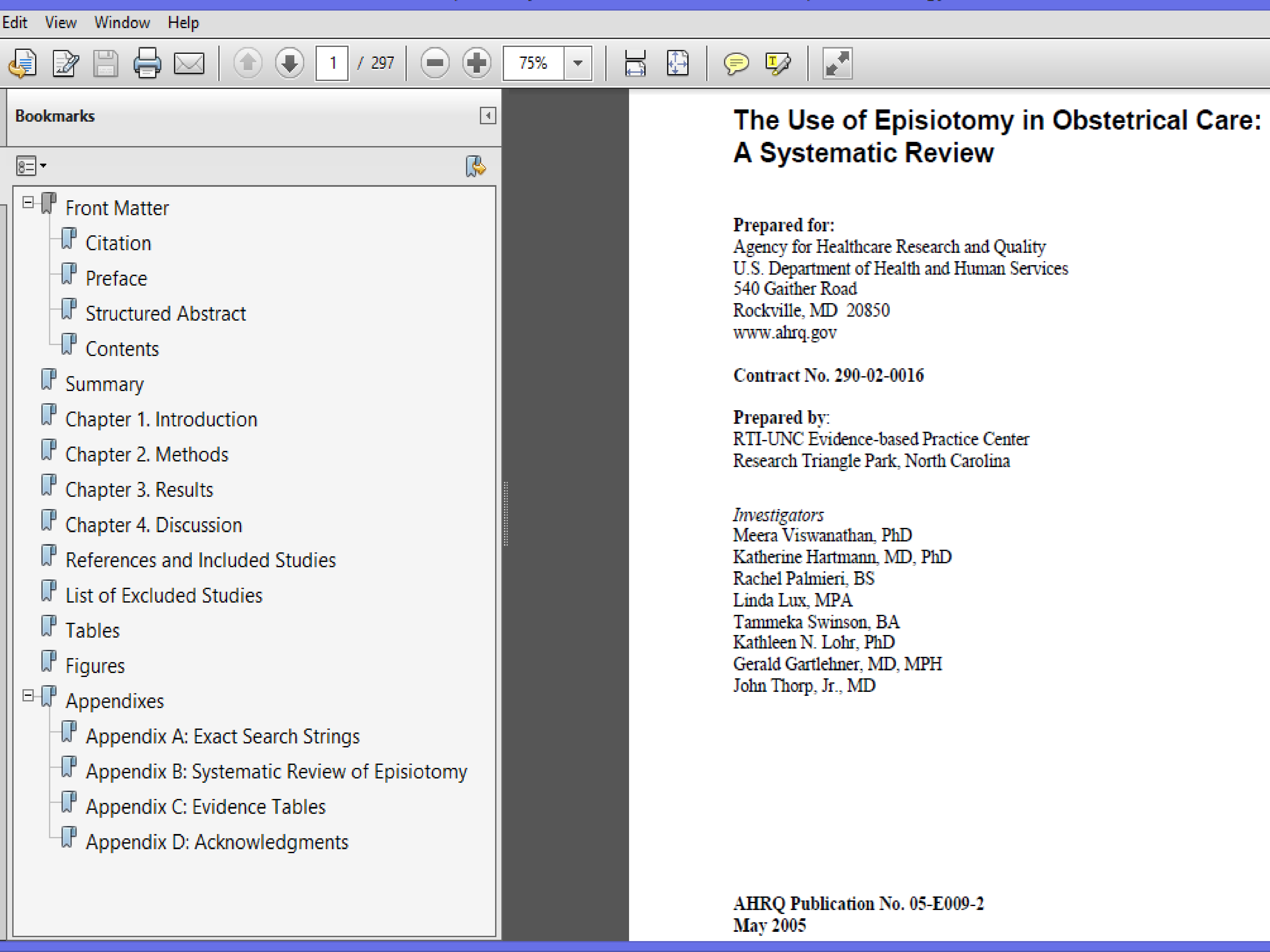
The benefits and risks of episiotomy in labor and delivery as recorded in the English language literature in over 350 books and articles published since 1860 are reviewed and analyzed. Episiotomy is performed in over 60 per cent of all deliveries in the United States and in a much higher per cent of primigravidas. Yet, there is no clearly defined evidence for its efficacy, particularly for routine use. In addition, although poorly studied, there is evidence that postpartum pain and discomfort are accentuated after episiotomy, and serious complications, including maternal death, can be associated with the procedure. Therefore, carefully designed controlled trials of benefit and risk should be carried out on the use of episiotomy.

Políticas de episiotomia restritivas comparadas à políticas de episiotomia de rotina, 8 RCT, 5541 mulheres, última revisão 2012

Campanha pela Abolição
da Episiotomia
de Rotina

Resultado	Risco relativo (CI 95%)	Estudos; pacientes
Trauma perineal grave	RR 0.67 (0.49 to 0.91)	7 RCT, 4404 mulheres
Necessidade de sutura	RR 0.71 (0.61 to 0.81)	5 RCT, 4133 mulheres
Complicações na cicatrização	RR 0.69 (0.56 to 0.85)	
Trauma perineal anterior	RR 1.84 (1.61 to 2.10)	6 RCT, 4896 mulheres
Qualquer dispareunia em 3 meses	RR 1.02 (0.90 to 1.16)	1 RCT, 895 mulheres
Incontinência urinária (3-7 meses)	RR 0.98 (0.79 to 1.20)	2 RCT, 1569 mulheres
Apgar < 7 no 5º minuto	RR 1.04 (0.76 to 1.43)	4 RCT, 3908 mulheres





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The Use of Episiotomy in Obstetrical Care: A Systematic Review

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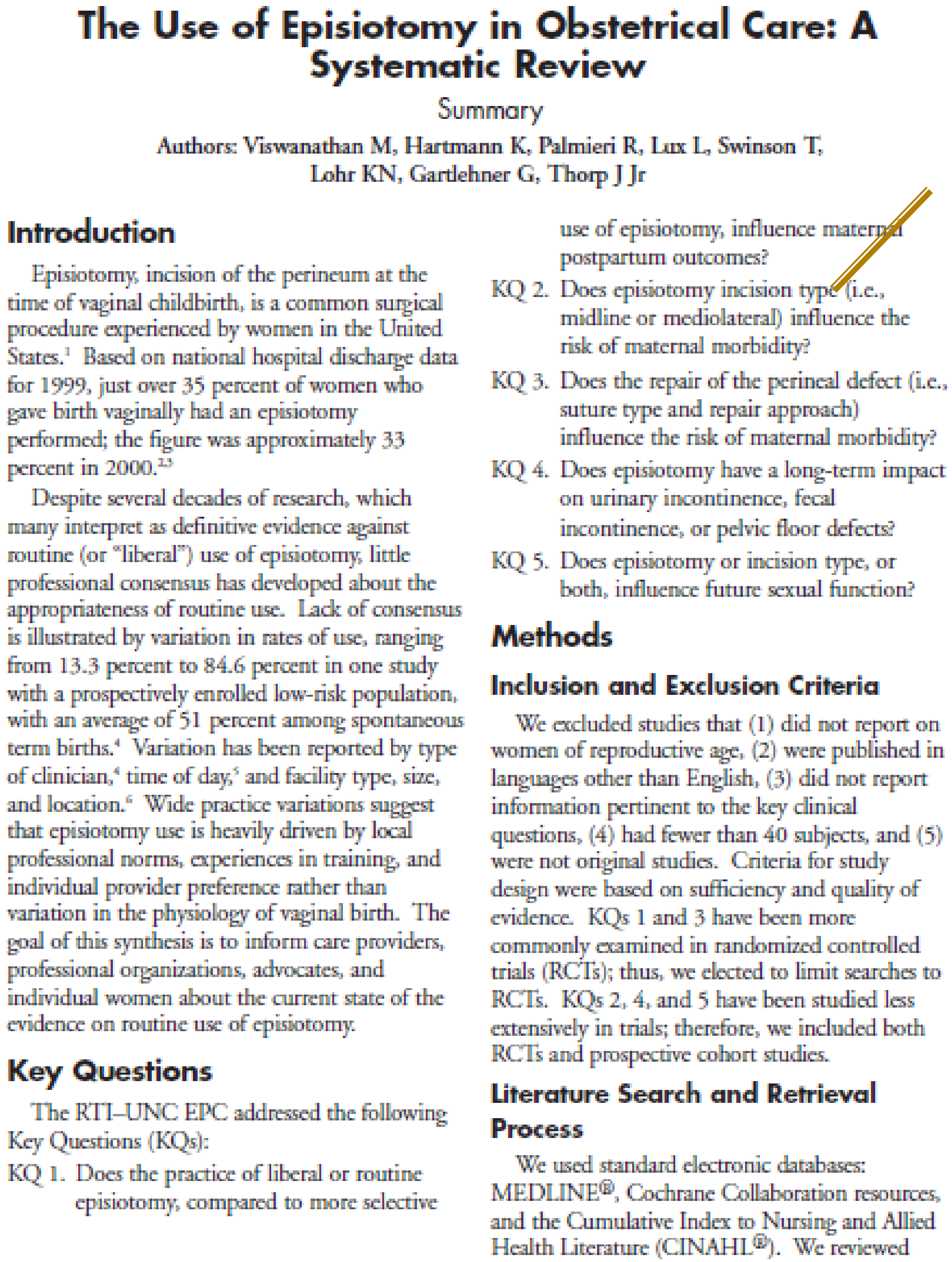


The Use of Episiotomy in Obstetrical Care: A Systematic Review

Summary

Authors: Viswanathan M, Hartmann K, Palmieri R, Lux L, Swinson T,
Lohr KN, Gartlehner G, Thorp J Jr

Introduction

Episiotomy, incision of the perineum at the time of vaginal childbirth, is a common surgical procedure experienced by women in the United States.[1] Based on national hospital discharge data for 1999, just over 35 percent of women who gave birth vaginally had an episiotomy performed; the figure was approximately 33 percent in 2000.[2,3]

Despite several decades of research, which many interpret as definitive evidence against routine (or "liberal") use of episiotomy, little professional consensus has developed about the appropriateness of routine use. Lack of consensus is illustrated by variation in rates of use, ranging from 13.3 percent to 84.6 percent in one study with a prospectively enrolled low-risk population, with an average of 51 percent among spontaneous term births.[4] Variation has been reported by type of clinician,[4] time of day,[5] and facility type, size, and location.[6] Wide practice variations suggest that episiotomy use is heavily driven by local professional norms, experiences in training, and individual provider preference rather than variation in the physiology of vaginal birth. The goal of this synthesis is to inform care providers, professional organizations, advocates, and individual women about the current state of the evidence on routine use of episiotomy.

Key Questions

The RTI–UNC EPC addressed the following Key Questions (KQs):

KQ 1. Does the practice of liberal or routine episiotomy, compared to more selective use of episiotomy, influence maternal postpartum outcomes?

KQ 2. Does episiotomy incision type (i.e., midline or mediolateral) influence the risk of maternal morbidity?

KQ 3. Does the repair of the perineal defect (i.e., suture type and repair approach) influence the risk of maternal morbidity?

KQ 4. Does episiotomy have a long-term impact on urinary incontinence, fecal incontinence, or pelvic floor defects?

KQ 5. Does episiotomy or incision type, or both, influence future sexual function?

Methods

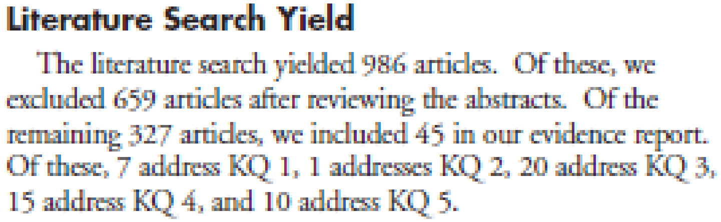
Inclusion and Exclusion Criteria

We excluded studies that (1) did not report on women of reproductive age, (2) were published in languages other than English, (3) did not report information pertinent to the key clinical questions, (4) had fewer than 40 subjects, and (5) were not original studies. Criteria for study design were based on sufficiency and quality of evidence. KQs 1 and 3 have been more commonly examined in randomized controlled trials (RCTs); thus, we elected to limit searches to RCTs. KQs 2, 4, and 5 have been studied less extensively in trials; therefore, we included both RCTs and prospective cohort studies.

Literature Search and Retrieval Process

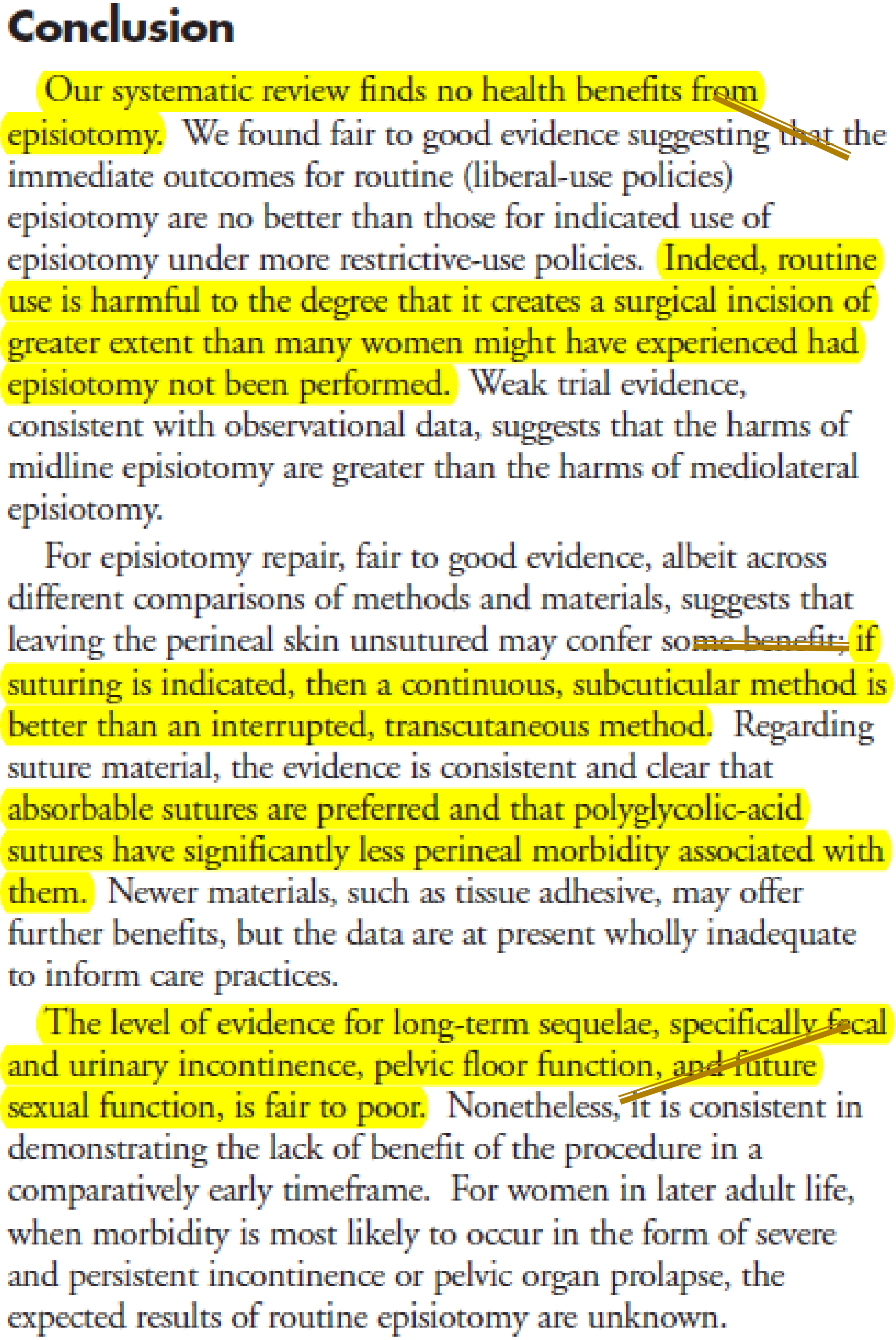
We used standard electronic databases: MEDLINE®, Cochrane Collaboration resources, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL®). We reviewed

1. Influencia sobre os resultados puerperais imediatos
2. Influencia dos tipos de episiotomia sobre a morbidade materna
3. Influencia dos métodos de reparo perineal sobre a morbidade materna
4. Impacto de longo prazo sobre incontinência urinária, fecal e defeitos do assoalho pélvico
5. Influencia do episiotomia ou tipo de incisão sobre a função sexual futura



Literature Search Yield

The literature search yielded 986 articles. Of these, we excluded 659 articles after reviewing the abstracts. Of the remaining 327 articles, we included 45 in our evidence report. Of these, 7 address KQ 1, 1 addresses KQ 2, 20 address KQ 3, 15 address KQ 4, and 10 address KQ 5.



Conclusion

Our systematic review finds no health benefits from episiotomy. We found fair to good evidence suggesting that the immediate outcomes for routine (liberal-use policies) episiotomy are no better than those for indicated use of episiotomy under more restrictive-use policies. Indeed, routine use is harmful to the degree that it creates a surgical incision of greater extent than many women might have experienced had episiotomy not been performed. Weak trial evidence, consistent with observational data, suggests that the harms of midline episiotomy are greater than the harms of mediolateral episiotomy.

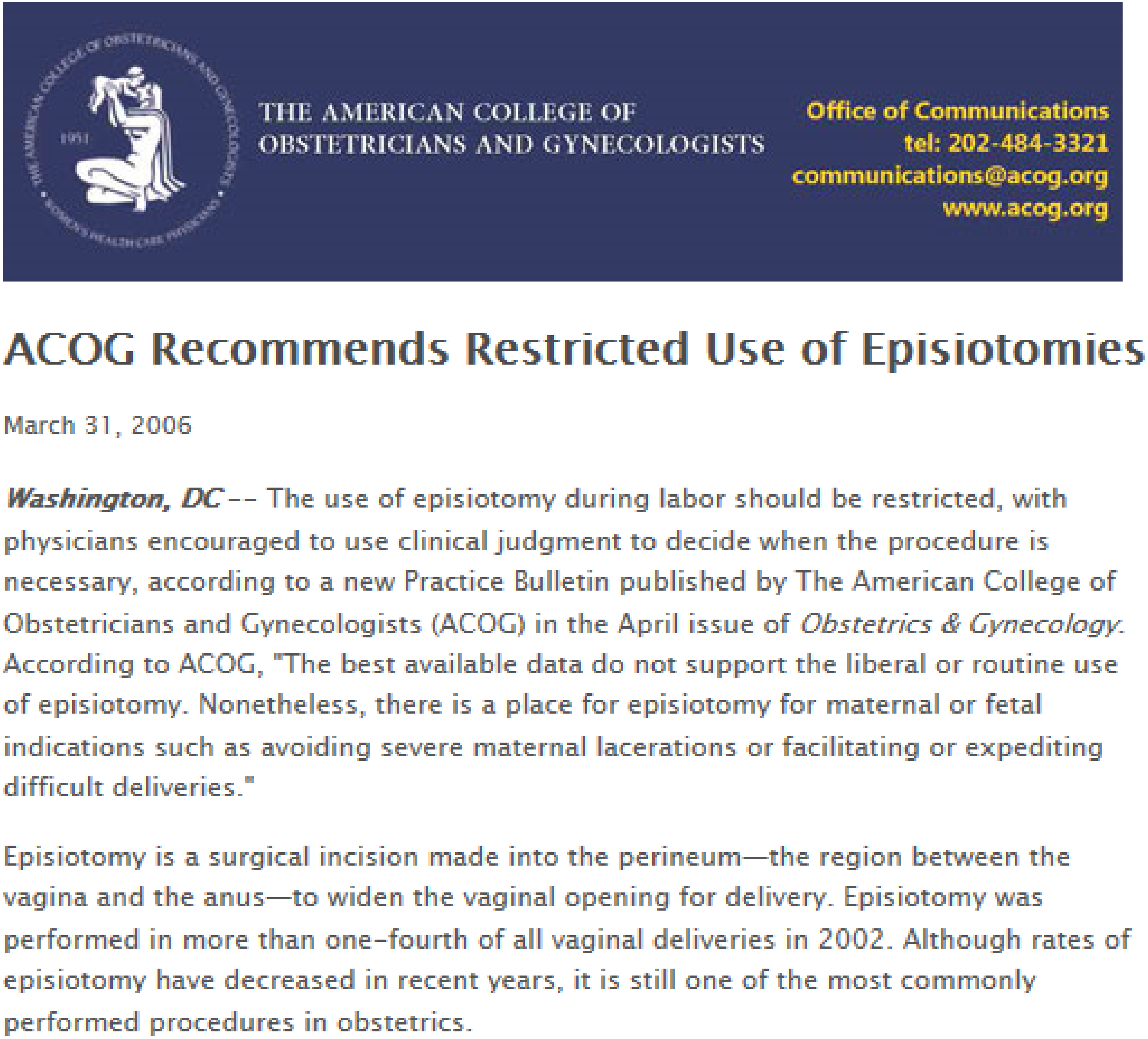
For episiotomy repair, fair to good evidence, albeit across different comparisons of methods and materials, suggests that leaving the perineal skin unsutured may confer some benefit; if suturing is indicated, then a continuous, subcuticular method is better than an interrupted, transcutaneous method. Regarding suture material, the evidence is consistent and clear that absorbable sutures are preferred and that polyglycolic-acid sutures have significantly less perineal morbidity associated with them. Newer materials, such as tissue adhesive, may offer further benefits, but the data are at present wholly inadequate to inform care practices.

The level of evidence for long-term sequelae, specifically fecal and urinary incontinence, pelvic floor function, and future sexual function, is fair to poor. Nonetheless, it is consistent in demonstrating the lack of benefit of the procedure in a comparatively early timeframe. For women in later adult life, when morbidity is most likely to occur in the form of severe and persistent incontinence or pelvic organ prolapse, the expected results of routine episiotomy are unknown.

Nossa revisão não encontrou benefícios para a episiotomia. Na verdade, a episiotomia de rotina é prejudicial, porque causa uma incisão cirúrgica mais extensa do que aquela que muitas mulheres teriam caso a episiotomia não tivesse sido realizada

Se a sutura for indicada, a sutura subcuticular, contínua, produz melhores resultados. O ácido poliglicólico tem menor morbidade

As evidências em relação a sequelas de longo prazo, como incontinência fecal e urinária, função do assoalho pélvico e função sexual futura, são fracas. No curto prazo, não foram demonstrados benefícios



THE AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS

Office of Communications
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www.acog.org

ACOG Recommends Restricted Use of Episiotomies

March 31, 2006

Washington, DC -- The use of episiotomy during labor should be restricted, with physicians encouraged to use clinical judgment to decide when the procedure is necessary, according to a new Practice Bulletin published by The American College of Obstetricians and Gynecologists (ACOG) in the April issue of *Obstetrics & Gynecology*. According to ACOG, "The best available data do not support the liberal or routine use of episiotomy. Nonetheless, there is a place for episiotomy for maternal or fetal indications such as avoiding severe maternal lacerations or facilitating or expediting difficult deliveries."

Episiotomy is a surgical incision made into the perineum—the region between the vagina and the anus—to widen the vaginal opening for delivery. Episiotomy was performed in more than one-fourth of all vaginal deliveries in 2002. Although rates of episiotomy have decreased in recent years, it is still one of the most commonly performed procedures in obstetrics.

“Tenho até feito uns partos humanizados, mas episiotomia ainda não consigo deixar de fazer”

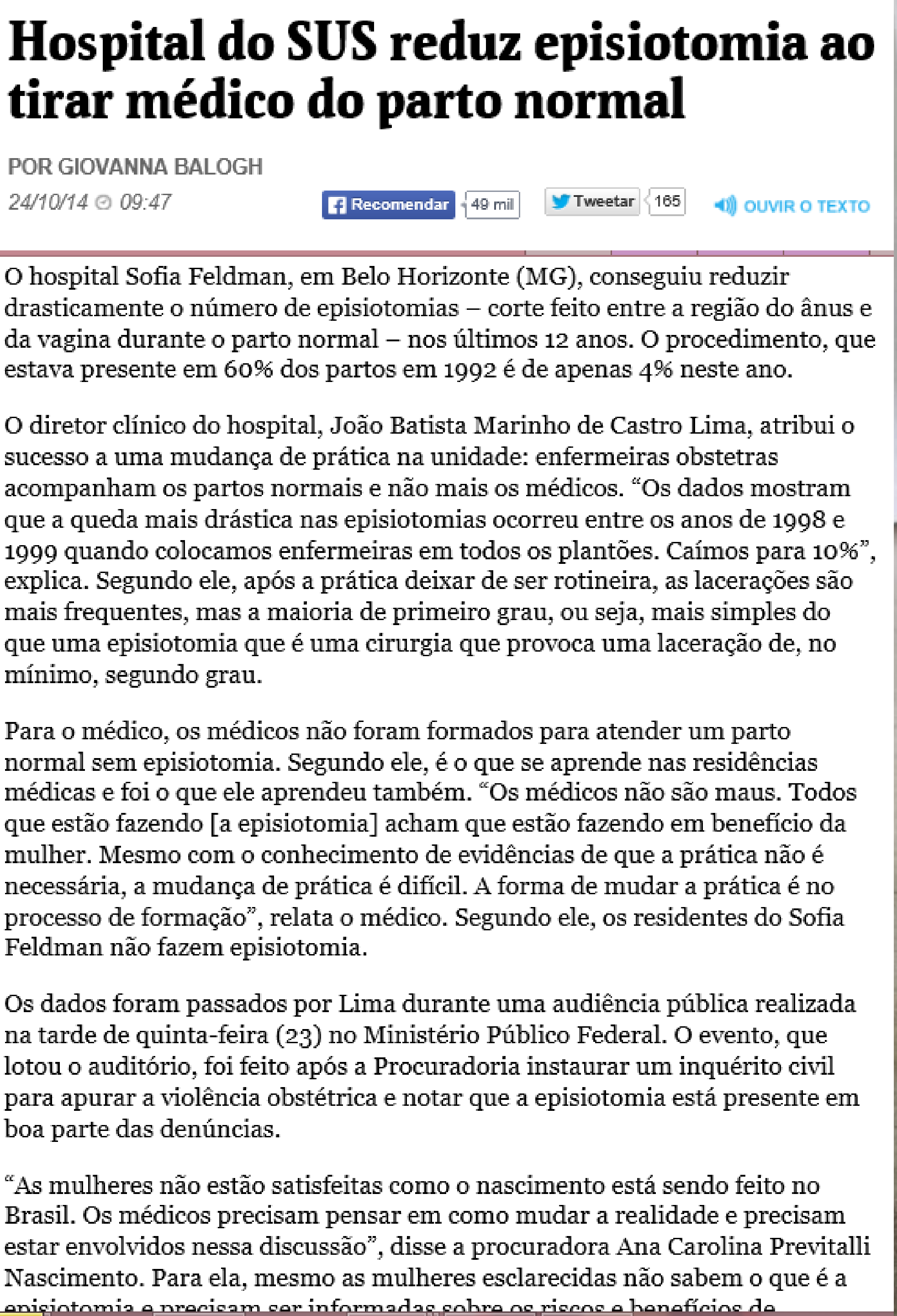
jovem preceptora de residência médica em GO – janeiro, 2014

- “episiotomia serve para evitar hipóxia neonatal, evitar lacerações na região do parto, se as mulheres não pensam em seus filhos que estão nascendo e não ligam para consequências tudo bem…depois não venham reclamar que a bexiga caiu…”

http://maternar.blogfolha.uol.com.br/2014/10/24/hospital-do-sus-reduz-episiotomia-ao-tirar-medico-do-parto-normal/

- Sou médico e residente de GO, tds as vezes que não foi feita a episotomia houve laceração muito maior q 1 grau, ja ocorre laceração de 1 quando há a episitomia imagina quando não se faz.... E episiotomia não é uma "cirurgia" como descrito na reportagem. E até hj só lacerações 3 e 4 quando não se fez episio e a gravidade e possíveis complicações para a paciente são terríveis (de 4 grau), minha humilde opinião

http://maternar.blogfolha.uol.com.br/2014/10/24/hospital-do-sus-reduz-episiotomia-ao-tirar-medico-do-parto-normal/



Hospital do SUS reduz episiotomia ao tirar médico do parto normal

POR GIOVANNA BALOGH

24/10/14 09:47

O hospital Sofia Feldman, em Belo Horizonte (MG), conseguiu reduzir drasticamente o número de episiotomias – corte feito entre a região do ânus e da vagina durante o parto normal – nos últimos 12 anos. O procedimento, que estava presente em 60% dos partos em 1992 é de apenas 4% neste ano.

O diretor clínico do hospital, João Batista Marinho de Castro Lima, atribui o sucesso a uma mudança de prática na unidade: enfermeiras obstetras acompanham os partos normais e não mais os médicos. "Os dados mostram que a queda mais drástica nas episiotomias ocorreu entre os anos de 1998 e 1999 quando colocamos enfermeiras em todos os plantões. Caímos para 10%", explica. Segundo ele, após a prática deixar de ser rotineira, as lacerações são mais frequentes, mas a maioria de primeiro grau, ou seja, mais simples do que uma episiotomia que é uma cirurgia que provoca uma laceração de, no mínimo, segundo grau.

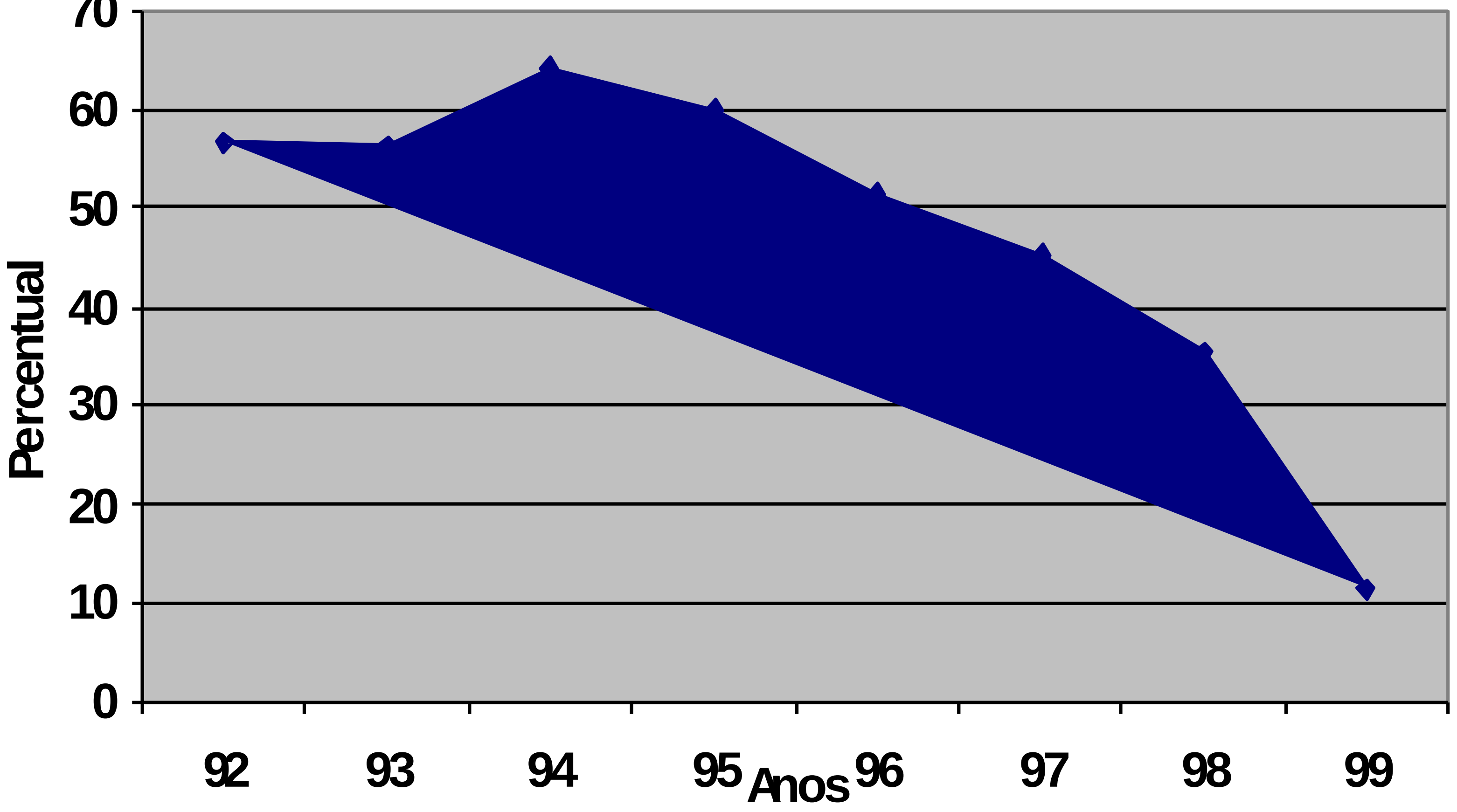
Para o médico, os médicos não foram formados para atender um parto normal sem episiotomia. Segundo ele, é o que se aprende nas residências médicas e foi o que ele aprendeu também. "Os médicos não são maus. Todos que estão fazendo [a episiotomia] acham que estão fazendo em benefício da mulher. Mesmo com o conhecimento de evidências de que a prática não é necessária, a mudança de prática é difícil. A forma de mudar a prática é no processo de formação", relata o médico. Segundo ele, os residentes do Sofia Feldman não fazem episiotomia.

Os dados foram passados por Lima durante uma audiência pública realizada na tarde de quinta-feira (23) no Ministério Público Federal. O evento, que lotou o auditório, foi feito após a Procuradoria instaurar um inquérito civil para apurar a violência obstétrica e notar que a episiotomia está presente em boa parte das denúncias.

"As mulheres não estão satisfeitas como o nascimento está sendo feito no Brasil. Os médicos precisam pensar em como mudar a realidade e precisam estar envolvidos nessa discussão", disse a procuradora Ana Carolina Previtalli Nascimento. Para ela, mesmo as mulheres esclarecidas não sabem o que é a episiotomia e precisam ser informadas sobre os riscos e benefícios de

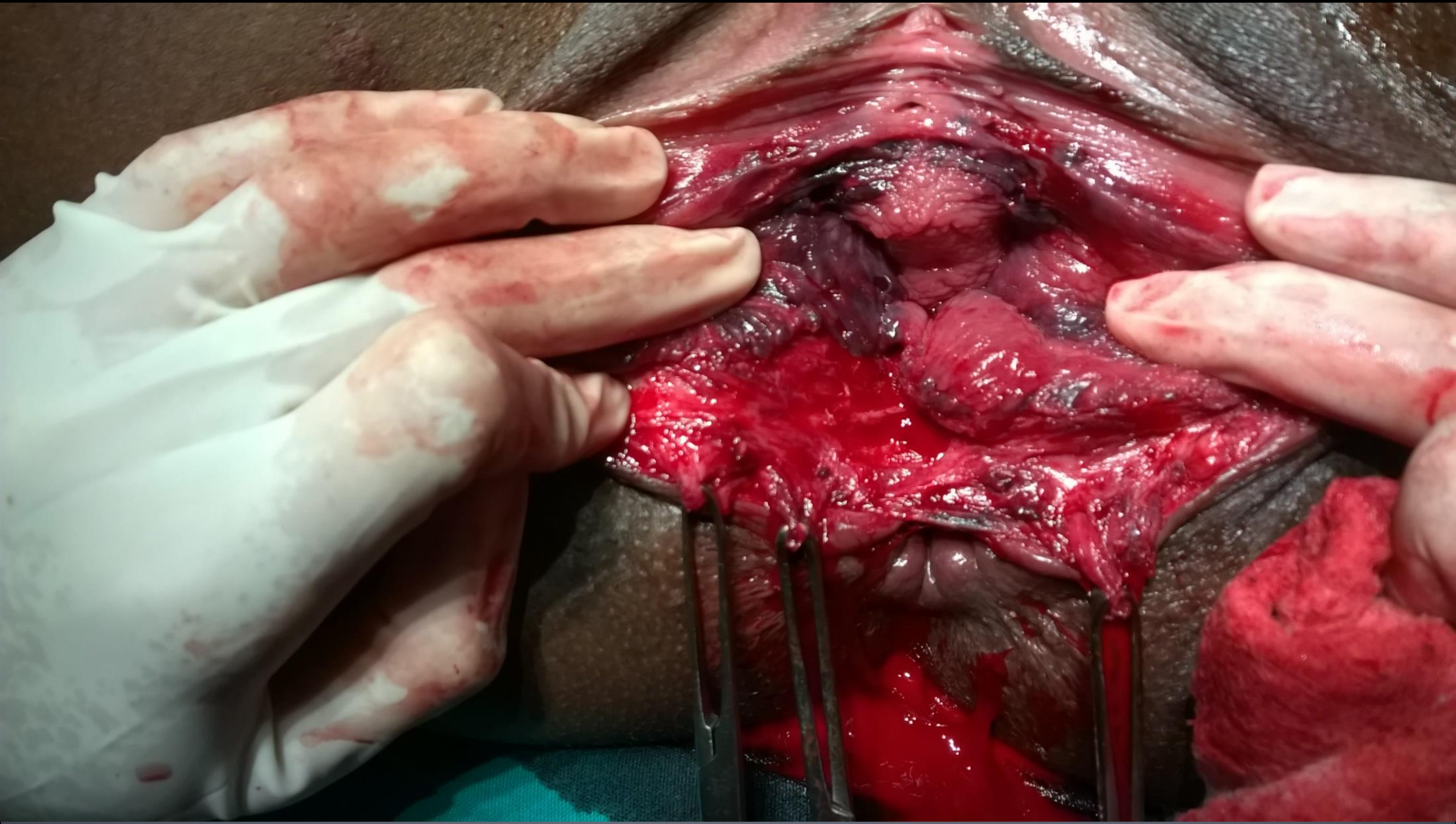
Hospital Sofia Feldman

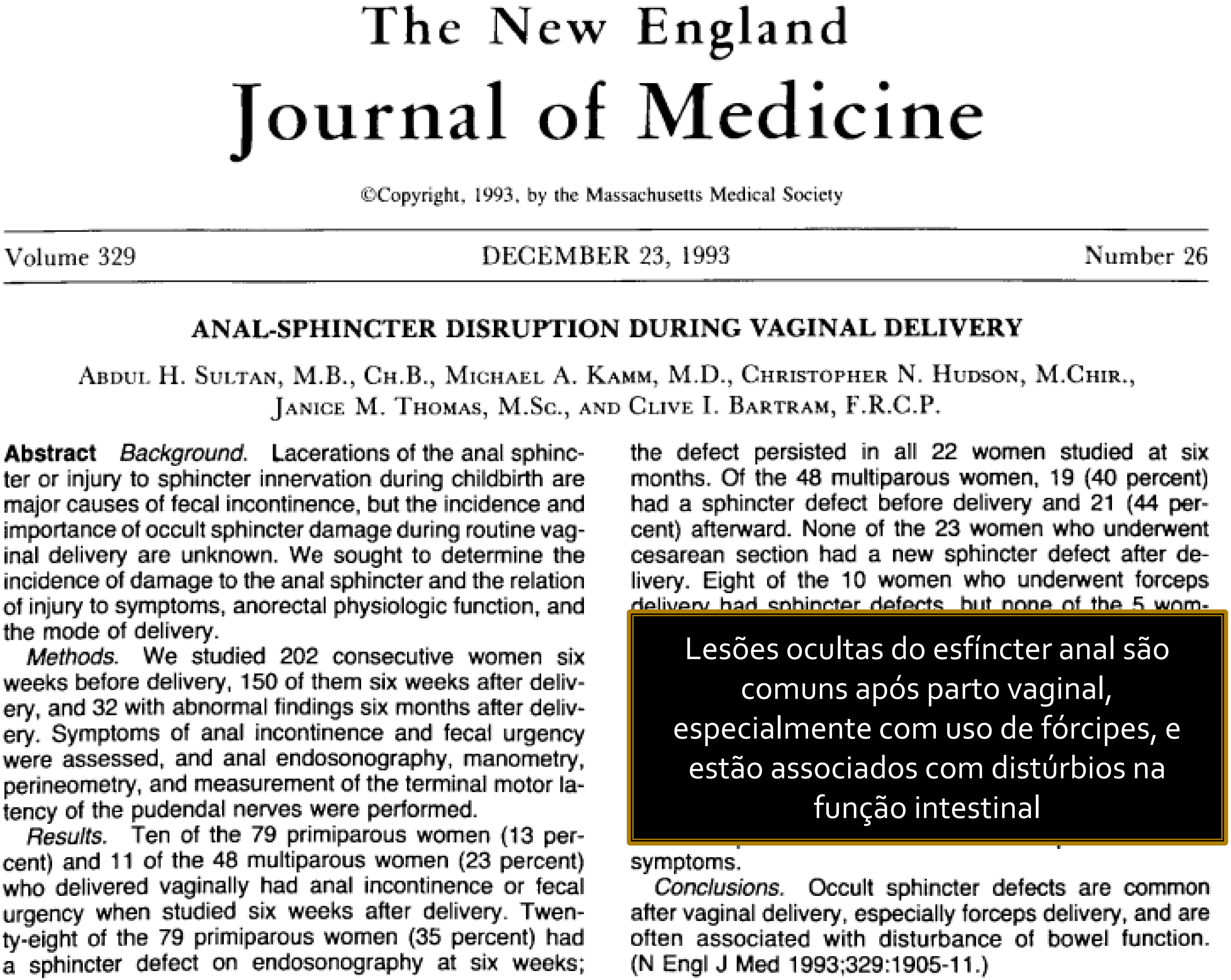
Tendência de realização de episiotomia
Hospital Sofia Feldman
1992-1999



Trauma obstétrico do esfíncter anal (TOEA)

Obstetric Anal Sphincter Injuries (OASIS)





The New England
Journal of Medicine

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Volume 329 DECEMBER 23, 1993 Number 26

ANAL-SPHINCTER DISRUPTION DURING VAGINAL DELIVERY

Abdul H. Sultan, M.B., Ch.B., Michael A. Kamm, M.D., Christopher N. Hudson, M.Chir.,
Janice M. Thomas, M.Sc., and Clive I. Bartram, F.R.C.P.

Abstract *Background.* Lacerations of the anal sphincter or injury to sphincter innervation during childbirth are major causes of fecal incontinence, but the incidence and importance of occult sphincter damage during routine vaginal delivery are unknown. We sought to determine the incidence of damage to the anal sphincter and the relation of injury to symptoms, anorectal physiologic function, and the mode of delivery.

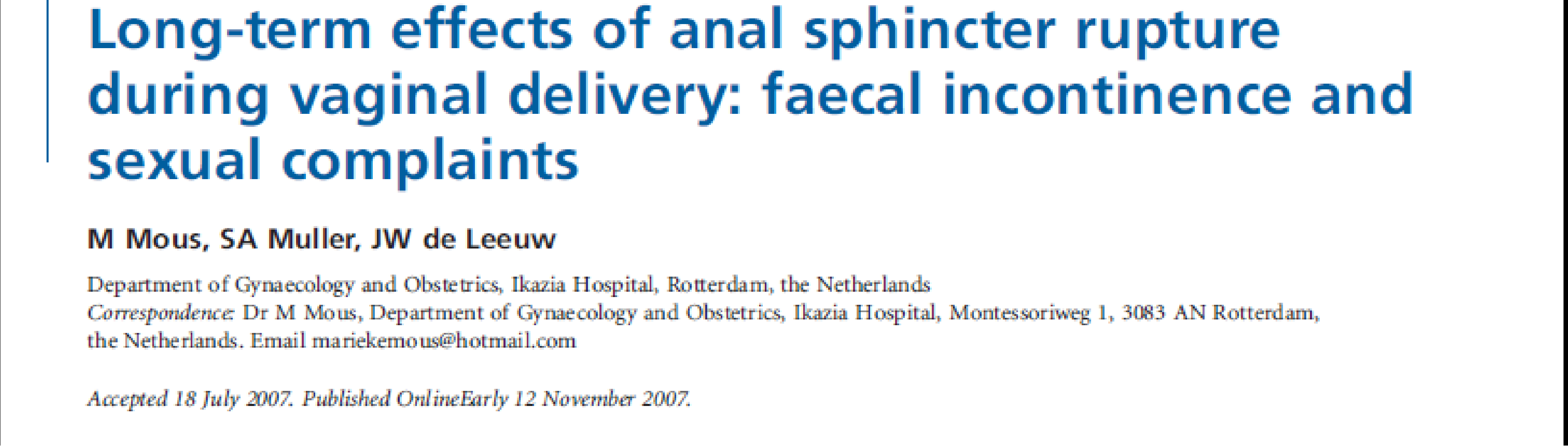
Methods. We studied 202 consecutive women six weeks before delivery, 150 of them six weeks after delivery, and 32 with abnormal findings six months after delivery. Symptoms of anal incontinence and fecal urgency were assessed, and anal endosonography, manometry, perineometry, and measurement of the terminal motor latency of the pudendal nerves were performed.

Results. Ten of the 79 primiparous women (13 percent) and 11 of the 48 multiparous women (23 percent) who delivered vaginally had anal incontinence or fecal urgency when studied six weeks after delivery. Twenty-eight of the 79 primiparous women (35 percent) had a sphincter defect on endosonography at six weeks; the defect persisted in all 22 women studied at six months. Of the 48 multiparous women, 19 (40 percent) had a sphincter defect before delivery and 21 (44 percent) afterward. None of the 23 women who underwent cesarean section had a new sphincter defect after delivery. Eight of the 10 women who underwent forceps delivery had sphincter defects, but none of the 5 wom-

symptoms.

Conclusions. Occult sphincter defects are common after vaginal delivery, especially forceps delivery, and are often associated with disturbance of bowel function. (N Engl J Med 1993;329:1905-11.)

Lesões ocultas do esfíncter anal são comuns após parto vaginal, especialmente com uso de fórcipes, e estão associados com distúrbios na função intestinal



Long-term effects of anal sphincter rupture during vaginal delivery: faecal incontinence and sexual complaints

M Mous, SA Muller, JW de Leeuw

Department of Gynaecology and Obstetrics, Ikazia Hospital, Rotterdam, the Netherlands
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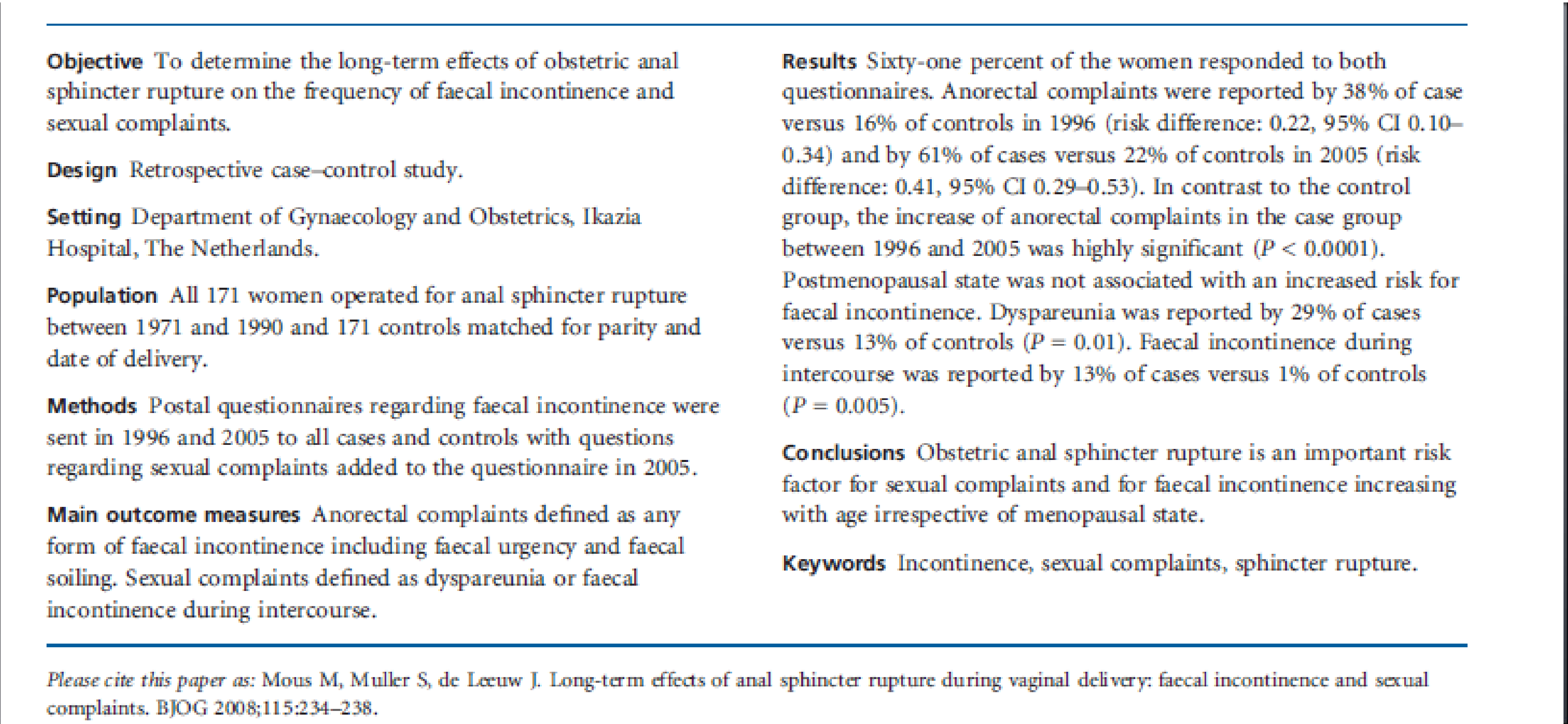


Objective To determine the long-term effects of obstetric anal sphincter rupture on the frequency of faecal incontinence and sexual complaints.

Design Retrospective case–control study.

Setting Department of Gynaecology and Obstetrics, Ikazia Hospital, The Netherlands.

Population All 171 women operated for anal sphincter rupture between 1971 and 1990 and 171 controls matched for parity and date of delivery.

Methods Postal questionnaires regarding faecal incontinence were sent in 1996 and 2005 to all cases and controls with questions regarding sexual complaints added to the questionnaire in 2005.

Main outcome measures Anorectal complaints defined as any form of faecal incontinence including faecal urgency and faecal soiling. Sexual complaints defined as dyspareunia or faecal incontinence during intercourse.

Results Sixty-one percent of the women responded to both questionnaires. Anorectal complaints were reported by 38% of case versus 16% of controls in 1996 (risk difference: 0.22, 95% CI 0.10–0.34) and by 61% of cases versus 22% of controls in 2005 (risk difference: 0.41, 95% CI 0.29–0.53). In contrast to the control group, the increase of anorectal complaints in the case group between 1996 and 2005 was highly significant ($P < 0.0001$). Postmenopausal state was not associated with an increased risk for faecal incontinence. Dyspareunia was reported by 29% of cases versus 13% of controls ($P = 0.01$). Faecal incontinence during intercourse was reported by 13% of cases versus 1% of controls ($P = 0.005$).

Conclusions Obstetric anal sphincter rupture is an important risk factor for sexual complaints and for faecal incontinence increasing with age irrespective of menopausal state.

Keywords Incontinence, sexual complaints, sphincter rupture.

Please cite this paper as: Mous M, Muller S, de Leeuw J. Long-term effects of anal sphincter rupture during vaginal delivery: faecal incontinence and sexual complaints. BJOG 2008;115:234–238.

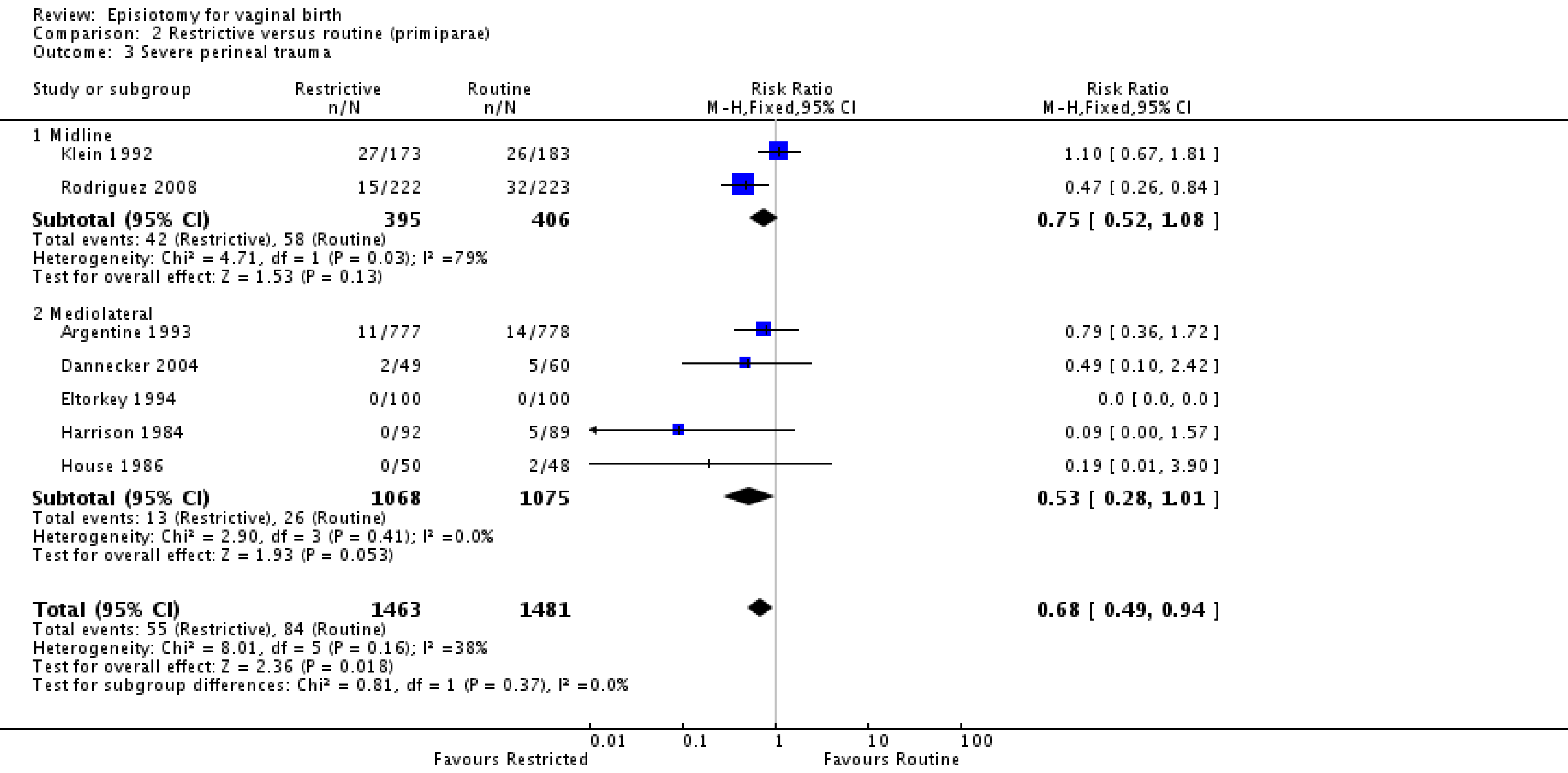
Trauma obstétrico do esfíncter anal Reino Unido

O índice de OASIS na Inglaterra (gestação única, cefálico, termo, primigesta) triplicou de 1.8% a 5.9% entre 2000 a 2012. A incidência geral no Reino Unido é de 2.9% (0-8%), com uma incidência de 6.1% em primiparas, comparado a 1.7% em multíparas.

RCOG. The Management of Third- and Fourth-Degree Perineal Tears
Green-top Guideline No. 29 . June 2015

Epsiotomia previne OASIS?

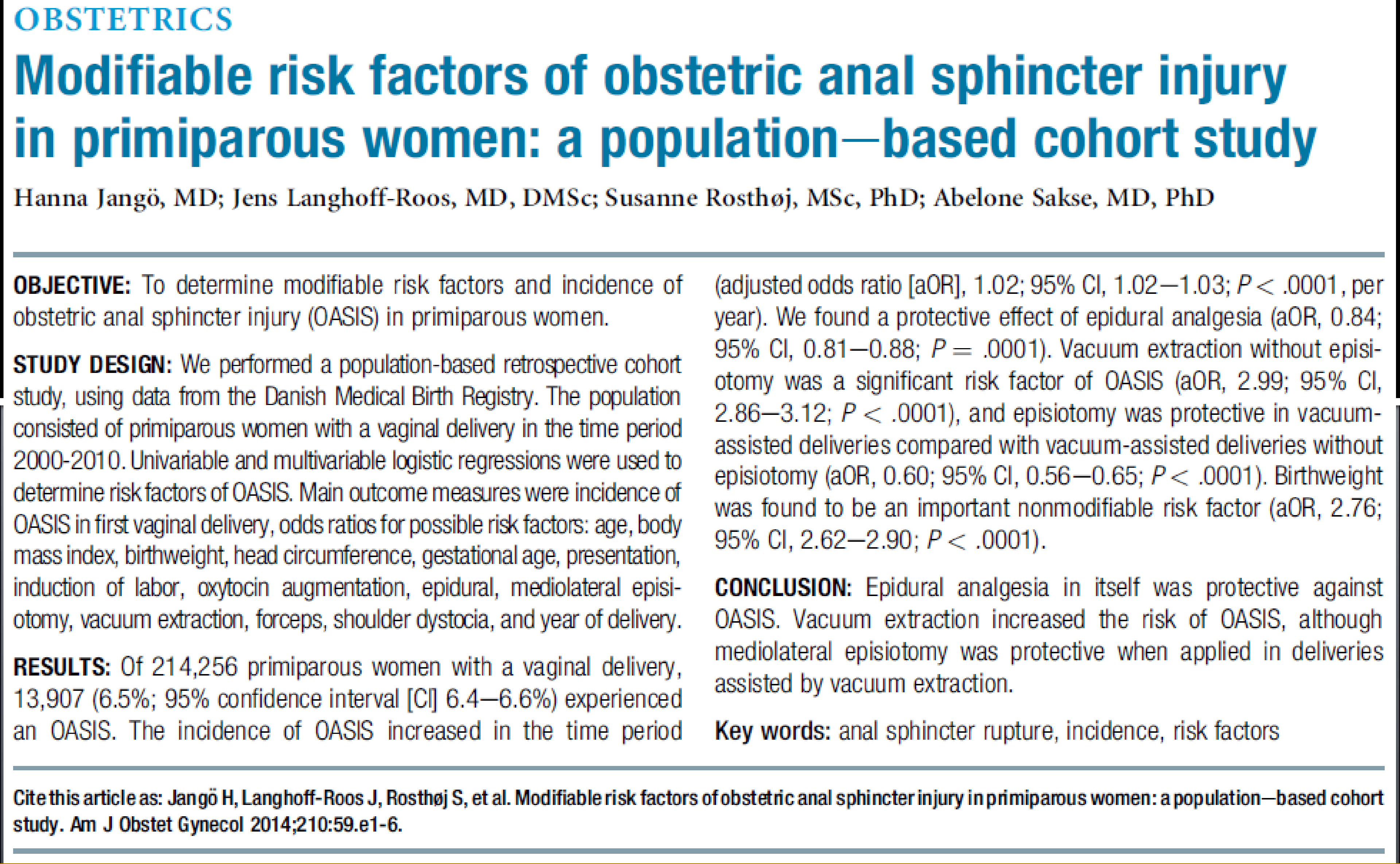
Resultado: trauma perineal grave



Review: Episiotomy for vaginal birth
Comparison: 2 Restrictive versus routine (primiparae)
Outcome: 3 Severe perineal trauma

Study or subgroup	Restrictive n/N	Routine n/N	Risk Ratio M-H,Fixed,95% CI
1 Midline			
Klein 1992	27/173	26/183	1.10 [0.67, 1.81]
Rodriguez 2008	15/222	32/223	0.47 [0.26, 0.84]
Subtotal (95% CI)	**395**	**406**	**0.75 [0.52, 1.08]**
Total events: 42 (Restrictive), 58 (Routine)			
Heterogeneity: Chi^2 = 4.71, df = 1 (P = 0.03); I^2 =79%			
Test for overall effect: Z = 1.53 (P = 0.13)			
2 Mediolateral			
Argentine 1993	11/777	14/778	0.79 [0.36, 1.72]
Dannecker 2004	2/49	5/60	0.49 [0.10, 2.42]
Eltorkey 1994	0/100	0/100	0.0 [0.0, 0.0]
Harrison 1984	0/92	5/89	0.09 [0.00, 1.57]
House 1986	0/50	2/48	0.19 [0.01, 3.90]
Subtotal (95% CI)	**1068**	**1075**	**0.53 [0.28, 1.01]**
Total events: 13 (Restrictive), 26 (Routine)			
Heterogeneity: Chi^2 = 2.90, df = 3 (P = 0.41); I^2 =0.0%			
Test for overall effect: Z = 1.93 (P = 0.053)			
Total (95% CI)	**1463**	**1481**	**0.68 [0.49, 0.94]**
Total events: 55 (Restrictive), 84 (Routine)			
Heterogeneity: Chi^2 = 8.01, df = 5 (P = 0.16); I^2 =38%			
Test for overall effect: Z = 2.36 (P = 0.018)			
Test for subgroup differences: Chi^2 = 0.81, df = 1 (P = 0.37), I^2 =0.0%			

Carroli Guillermo, Mignini Luciano. Episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. In: *The Cochrane Library,* Issue 9, Art. No. CD000081. DOI: 10.1002/14651858.CD000081.pub2 (última atualização 2008)



OBSTETRICS

Modifiable risk factors of obstetric anal sphincter injury in primiparous women: a population—based cohort study

Hanna Jangö, MD; Jens Langhoff-Roos, MD, DMSc; Susanne Rosthøj, MSc, PhD; Abelone Sakse, MD, PhD

OBJECTIVE: To determine modifiable risk factors and incidence of obstetric anal sphincter injury (OASIS) in primiparous women.

STUDY DESIGN: We performed a population-based retrospective cohort study, using data from the Danish Medical Birth Registry. The population consisted of primiparous women with a vaginal delivery in the time period 2000-2010. Univariable and multivariable logistic regressions were used to determine risk factors of OASIS. Main outcome measures were incidence of OASIS in first vaginal delivery, odds ratios for possible risk factors: age, body mass index, birthweight, head circumference, gestational age, presentation, induction of labor, oxytocin augmentation, epidural, mediolateral episiotomy, vacuum extraction, forceps, shoulder dystocia, and year of delivery.

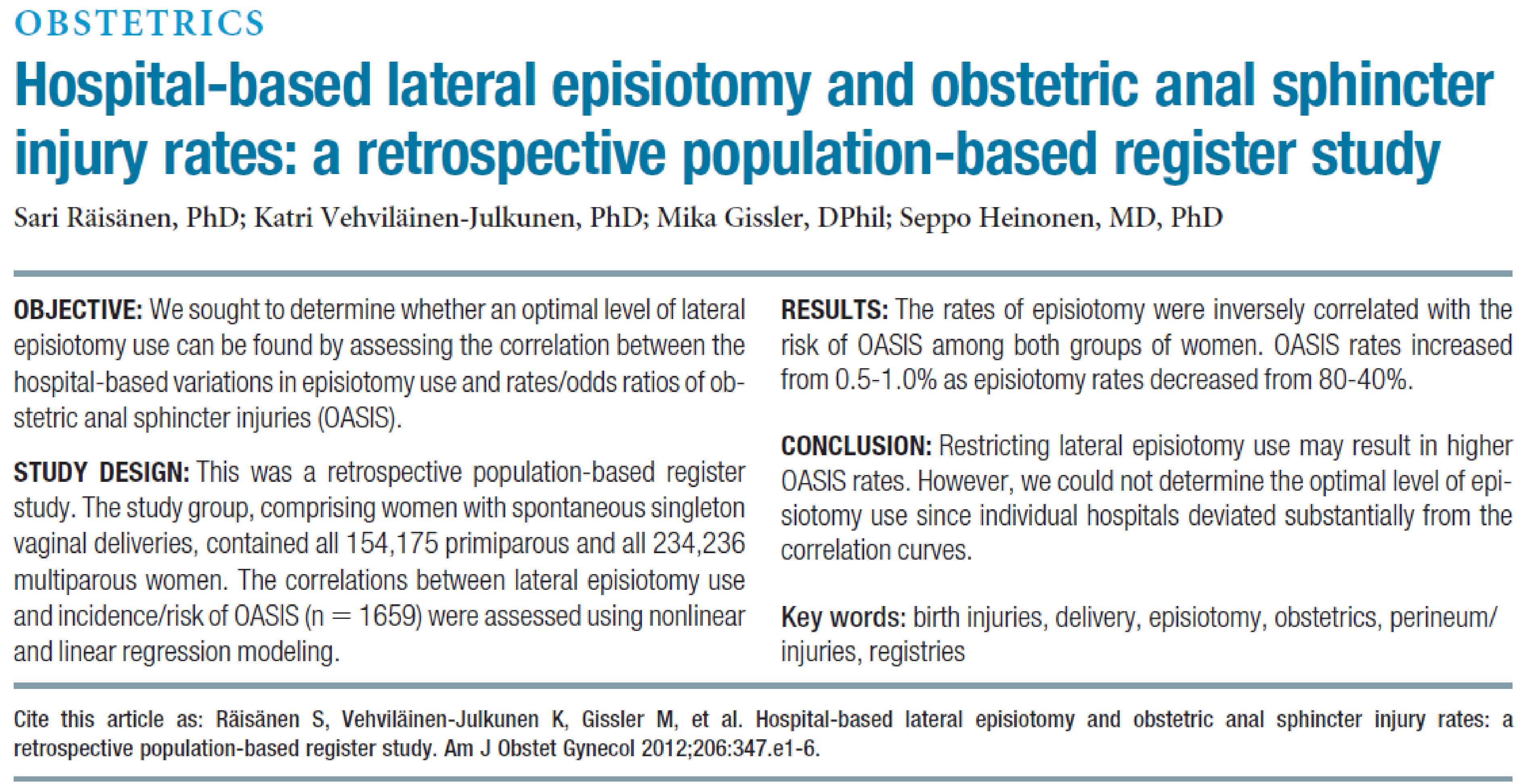
RESULTS: Of 214,256 primiparous women with a vaginal delivery, 13,907 (6.5%; 95% confidence interval [CI] 6.4—6.6%) experienced an OASIS. The incidence of OASIS increased in the time period (adjusted odds ratio [aOR], 1.02; 95% CI, 1.02—1.03; $P < .0001$, per year). We found a protective effect of epidural analgesia (aOR, 0.84; 95% CI, 0.81—0.88; $P = .0001$). Vacuum extraction without episiotomy was a significant risk factor of OASIS (aOR, 2.99; 95% CI, 2.86—3.12; $P < .0001$), and episiotomy was protective in vacuum-assisted deliveries compared with vacuum-assisted deliveries without episiotomy (aOR, 0.60; 95% CI, 0.56—0.65; $P < .0001$). Birthweight was found to be an important nonmodifiable risk factor (aOR, 2.76; 95% CI, 2.62—2.90; $P < .0001$).

CONCLUSION: Epidural analgesia in itself was protective against OASIS. Vacuum extraction increased the risk of OASIS, although mediolateral episiotomy was protective when applied in deliveries assisted by vacuum extraction.

Key words: anal sphincter rupture, incidence, risk factors

Cite this article as: Jangö H, Langhoff-Roos J, Rosthøj S, et al. Modifiable risk factors of obstetric anal sphincter injury in primiparous women: a population—based cohort study. Am J Obstet Gynecol 2014;210:59.e1-6.

Conclusão: analgesia peridural teve efeito protetor para OASIS. Vácuo-extração aumentou o risco de OASIS, embora ETML tenha efeito protetor quando aplicada em partos assistidos por vácuo.



OBSTETRICS

Hospital-based lateral episiotomy and obstetric anal sphincter injury rates: a retrospective population-based register study

Sari Räisänen, PhD; Katri Vehviläinen-Julkunen, PhD; Mika Gissler, DPhil; Seppo Heinonen, MD, PhD

OBJECTIVE: We sought to determine whether an optimal level of lateral episiotomy use can be found by assessing the correlation between the hospital-based variations in episiotomy use and rates/odds ratios of obstetric anal sphincter injuries (OASIS).

STUDY DESIGN: This was a retrospective population-based register study. The study group, comprising women with spontaneous singleton vaginal deliveries, contained all 154,175 primiparous and all 234,236 multiparous women. The correlations between lateral episiotomy use and incidence/risk of OASIS (n = 1659) were assessed using nonlinear and linear regression modeling.

RESULTS: The rates of episiotomy were inversely correlated with the risk of OASIS among both groups of women. OASIS rates increased from 0.5-1.0% as episiotomy rates decreased from 80-40%.

CONCLUSION: Restricting lateral episiotomy use may result in higher OASIS rates. However, we could not determine the optimal level of episiotomy use since individual hospitals deviated substantially from the correlation curves.

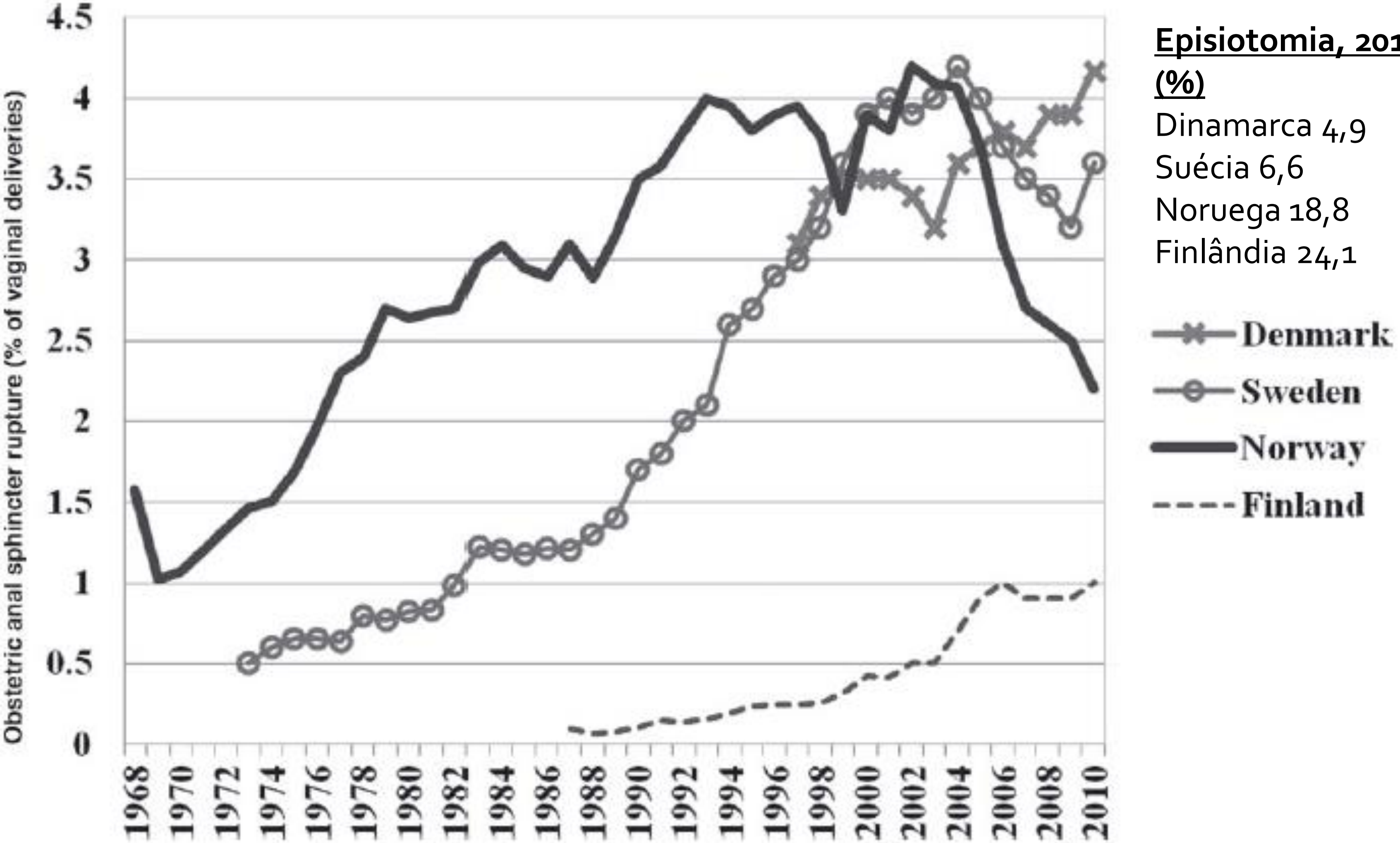
Key words: birth injuries, delivery, episiotomy, obstetrics, perineum/injuries, registries

Cite this article as: Räisänen S, Vehviläinen-Julkunen K, Gissler M, et al. Hospital-based lateral episiotomy and obstetric anal sphincter injury rates: a retrospective population-based register study. Am J Obstet Gynecol 2012;206:347.e1-6.

CONCLUSÃO: A restrição no uso de episiotomia lateral pode resultar em maiores índices de TOEA (Trauma obstétrico do esfíncter anal). Entretanto , não podemos determinar o nível ótimo de episiotomia, porque hospitais individuais desviaram substancialmente da curva de correlação

Rates of episiotomy and risk of OASIS among primiparous women with spontaneous vaginal deliveries

Hospital	Births, n	OASIS, %	OR of OASIS (95% CI)[a]	Episiotomy rate, %
A	15,780	0.5	1.86 (0.96–3.61)	71
B	14,867	0.8	2.86 (1.50–5.46)	56
C	13,231	1.7	6.73 (3.56–12.70)	45
D	7478	0.6	2.46 (1.24–4.88)	46
E	10,382	0.7	2.92 (1.51–5.66)	60
F	20,296	1.1	4.07 (2.15–7.68)	44
G	3886	0.3	1	71
H	8718	0.9	3.41 (1.76–6.60)	62
I	5120	0.7	2.87 (1.42–5.81)	67
J	3792	1.0	4.12 (2.05–8.27)	57
K	4623	1.0	4.04 (2.03–8.03)	38
L	3563	0.1	0.46 (0.14–1.47)	53
M	5970	0.5	2.07 (1.01–4.24)	84
N	4325	0.3	1.39 (0.62–3.09)	74
O	2938	0.9	3.52 (1.70–7.30)	53
P	5975	0.4	1.54 (0.73–3.22)	86
Q	5927	0.9	3.61 (1.84–7.10)	81
R	4738	0.6	2.34 (1.13–4.82)	64
S	12,566	1.0	3.45 (1.81–6.59)	64
Pooled	154,175	0.8		62



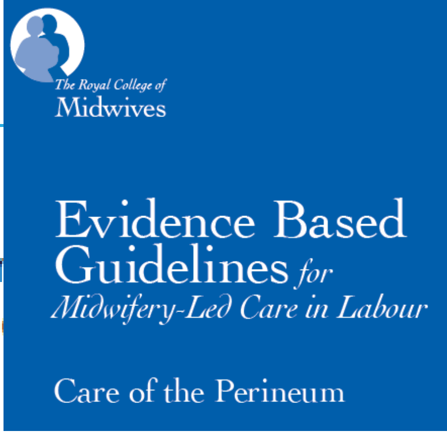
Episiotomia, 2010 (%)
Dinamarca 4,9
Suécia 6,6
Noruega 18,8
Finlândia 24,1

Figure 1. Incidence of obstetric anal sphincter rupture (as a percentage of vaginal deliveries) throughout the most recent decades in four Nordic countries.

Trauma Obstétrico do Esfíncter Anal parece ser prevenível em certo grau, conforme indicado pela rápida e duradoura redução em sua incidência após a implantação de programas de proteção perineal na Noruega

Laine K, Rotvold W, Staff AC. **Are obstetric anal sphincter ruptures preventable? – Large and consistent rupture rate variations between the Nordic countries and between delivery units in Norway**. Acta Obstet Gynecol Scand 2013;92:94-100

É possível prevenir?



The Royal College of Midwives

Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

Care of the Perineum

Antenatal perineal massage carried out by the mother or her partner i
is an effective approach to reduce perineal trauma among women wh
previous vaginal birth (Beckmann and Garrett 2006).

Women should be offered the application of warm compresses in the second stage of labour as this may reduce perineal trauma and the intervention is acceptable to both women and midwives (Aasheim et al. 2011).

Studies are inconclusive on using guidance or flexion of the presenting part with the aim of reducing perineal trauma (Aasheim et al. 2011; Pirhonen et al 1998; Myrfield 1997). NICE (2007) recommend that either the 'hands on' or the 'hands poised' technique can be used to facilitate spontaneous birth.

There is no evidence of short-term or long-term maternal benefit to support the use of routine episiotomy (Carroli and Mignini 2009).

Episiotomy has been associated with increased risk of severe perineal trauma (Dudding et al. 2008; Eason et al. 2000; Renfrew et al. 1998; Albers et al. 1999).

1. Técnicas ante-natais

1.1. Massagem perineal antenatal

Resultados	Estudos	n	Estatística	Efeito
Perineal trauma requiring suturing	4	2480	Risk Ratio (M-H, Fixed, 95% CI)	0.91 [0.86, 0.96]
1.1 Women without previous vaginal birth	4	1988	Risk Ratio (M-H, Fixed, 95% CI)	0.90 [0.84, 0.96]
1.2 Women with previous vaginal birth	1	492	Risk Ratio (M-H, Fixed, 95% CI)	0.95 [0.83, 1.08]
3rd or 4th degree perineal trauma	4	2480	Risk Ratio (M-H, Fixed, 95% CI)	0.81 [0.56, 1.18]
4.1 Women without previous vaginal birth	4	1988	Risk Ratio (M-H, Fixed, 95% CI)	0.82 [0.56, 1.20]
4.2 Women with previous vaginal birth	1	492	Risk Ratio (M-H, Fixed, 95% CI)	0.50 [0.05, 5.52]

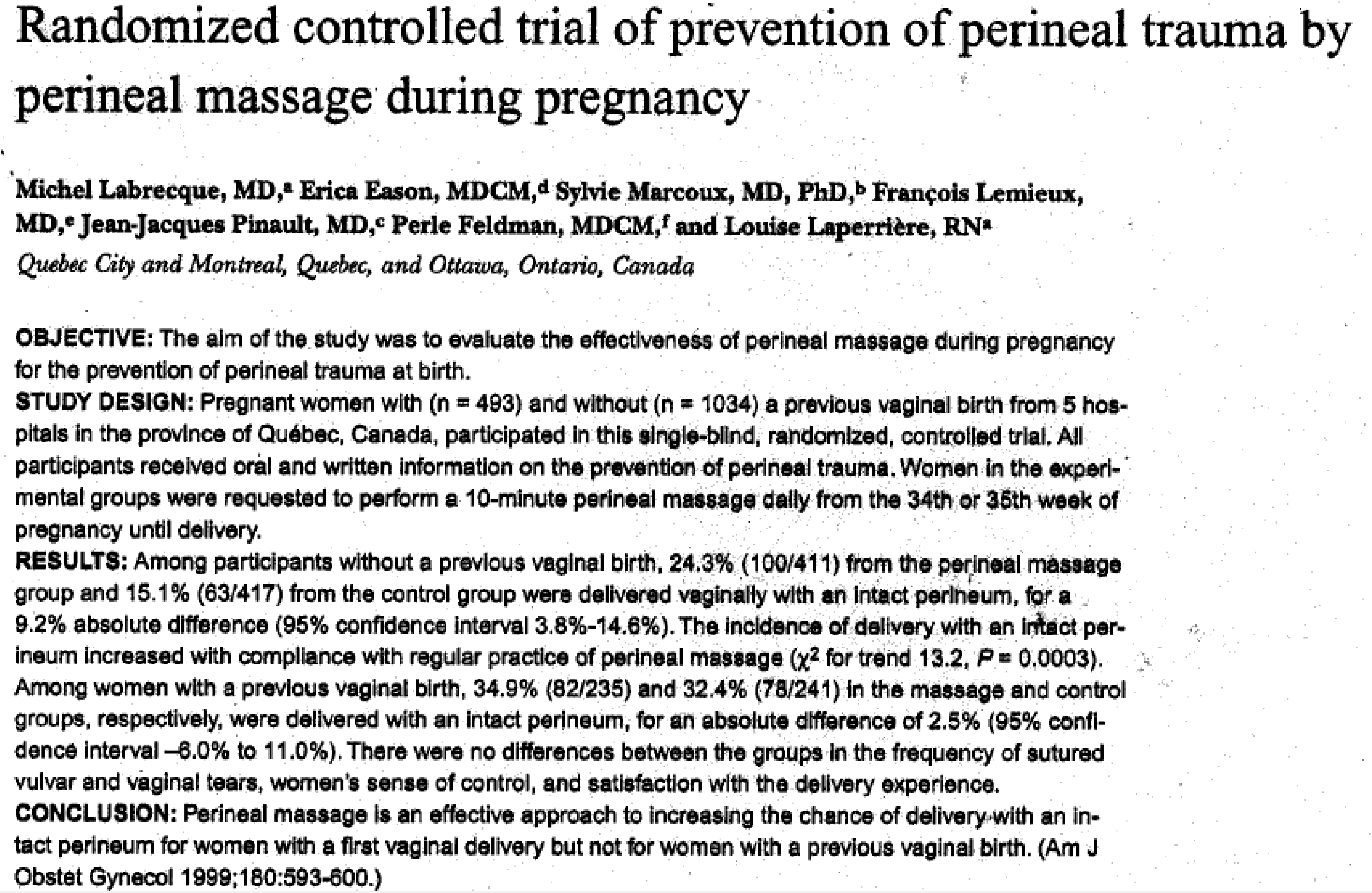
Beckmann Michael M, Stock Owen M. **Antenatal perineal massage for reducing perineal trauma**. Cochrane Database of Systematic Reviews. Ultima atualização: 2012

Massagem perineal antenatal

Quatro estudos (2497 women). Todos de boa qualidade.

- Massagem reduz a probabilidade de trauma perineal (principalmente episiotomies) e o relato de dor perineal, e geralmente é bem aceito pelas mulheres. As mulheres devem ser informadas dos prováveis benefícios da massagem perineal e de como realizer a massagem

Beckmann Michael M, Stock Owen M. **Antenatal perineal massage for reducing perineal trauma**. Cochrane Database of Systematic Reviews. Ultima atualização: 2012



Randomized controlled trial of prevention of perineal trauma by perineal massage during pregnancy

Michel Labrecque, MD,[a] Erica Eason, MDCM,[d] Sylvie Marcoux, MD, PhD,[b] François Lemieux, MD,[e] Jean-Jacques Pinault, MD,[c] Perle Feldman, MDCM,[f] and Louise Laperrière, RN[a]

Quebec City and Montreal, Quebec, and Ottawa, Ontario, Canada

OBJECTIVE: The aim of the study was to evaluate the effectiveness of perineal massage during pregnancy for the prevention of perineal trauma at birth.

STUDY DESIGN: Pregnant women with (n = 493) and without (n = 1034) a previous vaginal birth from 5 hospitals in the province of Québec, Canada, participated in this single-blind, randomized, controlled trial. All participants received oral and written information on the prevention of perineal trauma. Women in the experimental groups were requested to perform a 10-minute perineal massage daily from the 34th or 35th week of pregnancy until delivery.

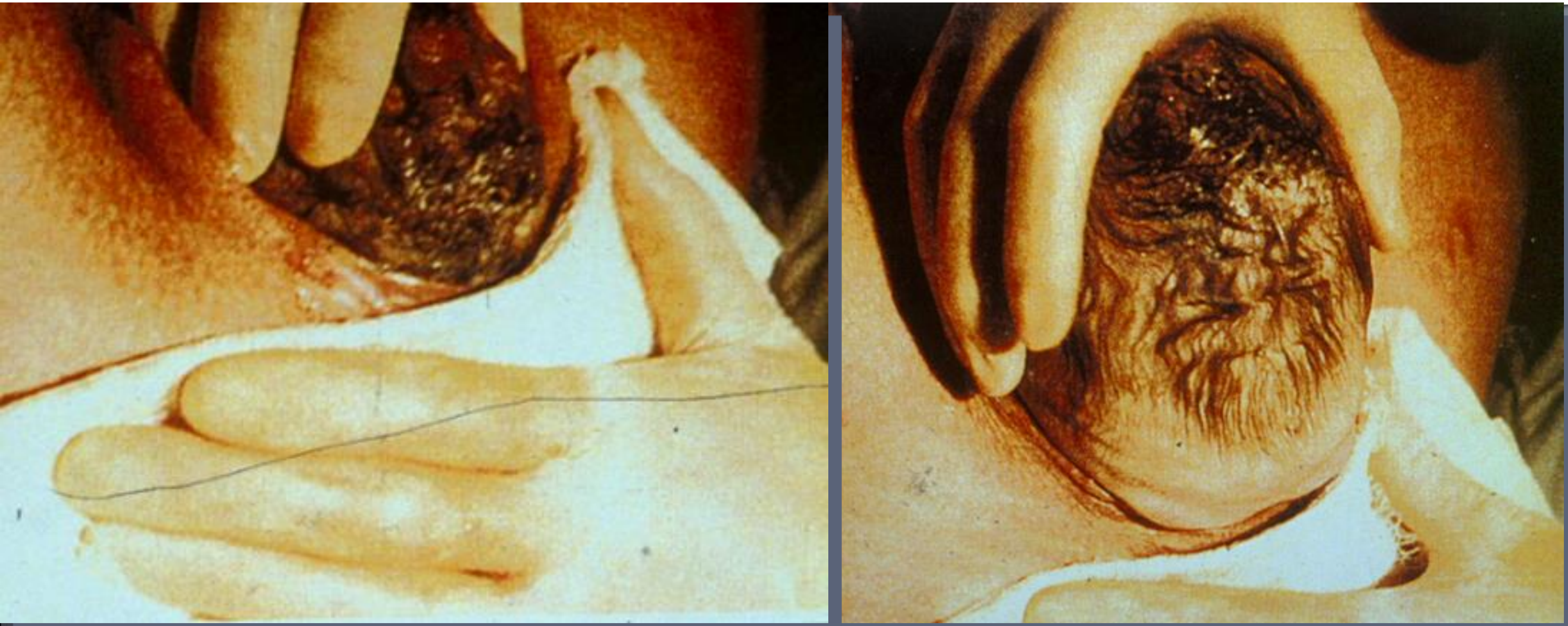
RESULTS: Among participants without a previous vaginal birth, 24.3% (100/411) from the perineal massage group and 15.1% (63/417) from the control group were delivered vaginally with an intact perineum, for a 9.2% absolute difference (95% confidence interval 3.8%-14.6%). The incidence of delivery with an intact perineum increased with compliance with regular practice of perineal massage (χ^2 for trend 13.2, $P = 0.0003$). Among women with a previous vaginal birth, 34.9% (82/235) and 32.4% (78/241) in the massage and control groups, respectively, were delivered with an intact perineum, for an absolute difference of 2.5% (95% confidence interval –6.0% to 11.0%). There were no differences between the groups in the frequency of sutured vulvar and vaginal tears, women's sense of control, and satisfaction with the delivery experience.

CONCLUSION: Perineal massage is an effective approach to increasing the chance of delivery with an intact perineum for women with a first vaginal delivery but not for women with a previous vaginal birth. (Am J Obstet Gynecol 1999;180:593-600.)

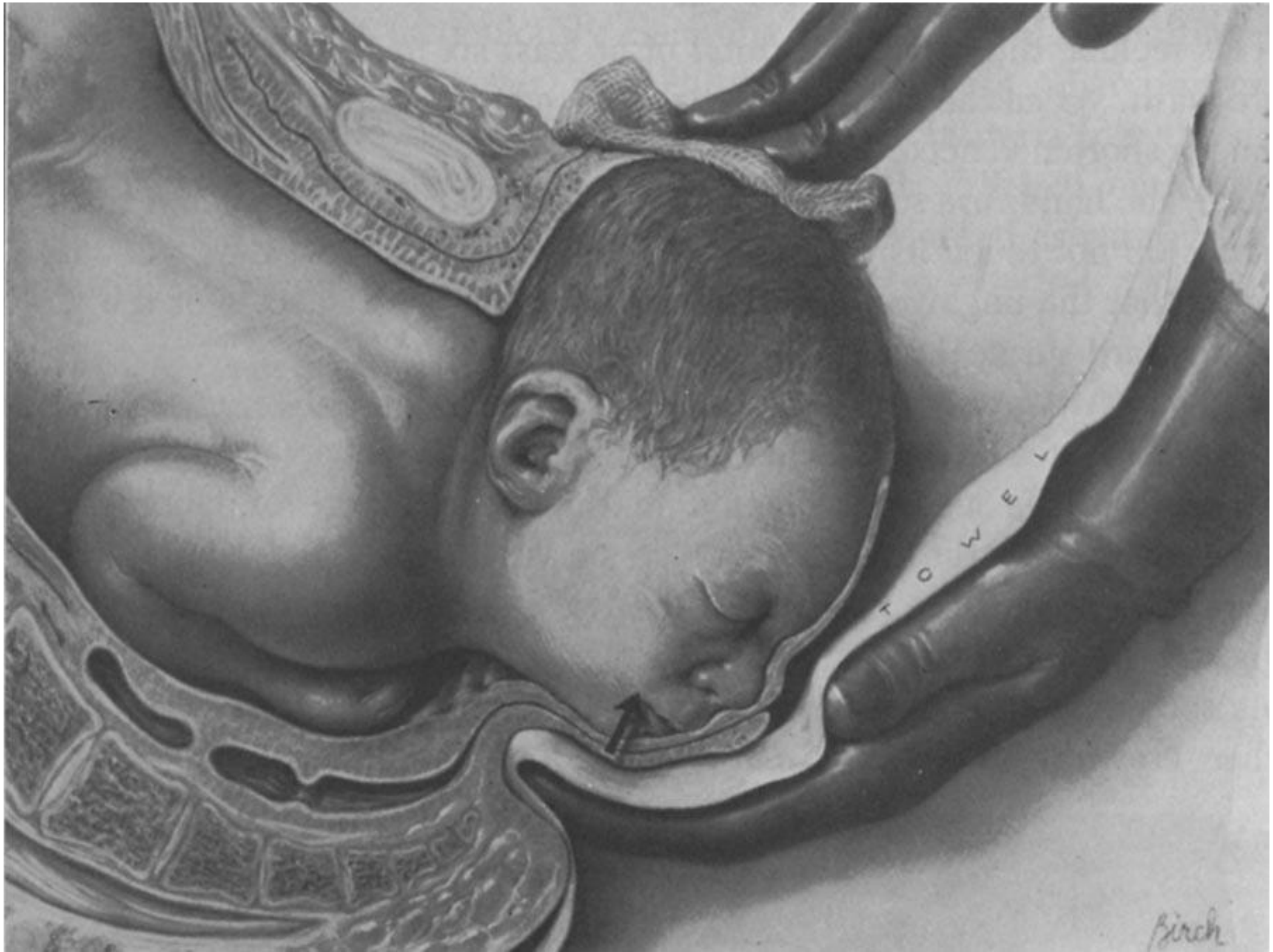
Técnica: introduzir 1 ou 2 dedos 3-4 cm na vagina e aplicar uma pressão na parede posterior e nas paredes laterais, por 2 minutos – 10 minutos diários. Pode-se usar óleo de amêndoa. A partir de 34-35 semanas

2. Técnicas intra-parto

2.1. Mãos no períneo



2.2. Manobra de Ritgen


TOWEL
Birch

Das Dammschutzverfahren nach Ritgen.

Von

Dr. med. **Ahlfeld.**

In der Monatsschrift für Geburtskunde, Band 6, Seite 339, empfiehlt v. Ritgen, um den Kopf in der wehenfreien Zeit durch den Damm hindurch zu drücken, die eine Hand so auf den Hinterdamm zu legen, dass die Spitzen der Finger hinter der Oeffnung des Afters, zunächst der Spitze des Steissbeins zu liegen kommen. Mit diesen Fingern soll unter der Wehenpause, am besten gleich nach dem Aufhören der Wehe, ein Druck nach innen und vorn ausgeübt werden, welcher gewöhnlich das Kinn des Kindes treffen und dasselbe zum Vorwärtsgleiten bringen soll.

An einer anderen Stelle, Band 8, Seite 234, schreibt Ritgen: Wir scheuen uns nicht zu sagen, dass wir in Fällen, in welchen es darauf ankam, den in die Scheide noch nicht tief herabgetretenen Kopf rasch zu Tage zu fördern, einen oder zwei Finger wohl eingeölt hoch in den Mastdarm gebracht und durch einen nach ab- und vorwärts gerichteten Druck oberhalb des hier an-

The Ritgen Maneuver

Another Sacred Cow Questioned

210 VOL. 112, NO. 2, PART 1, AUGUST 2008 **OBSTETRICS & GYNECOLOGY**

F. Gary Cunningham, MD

Ferdinand August Marie Franz von Ritgen (1787–1867) was a German physician who is credited with the perineum-sparing maneuver that bears his name.[1] In the first edition of *Williams Obstetrics*,[2] the maneuver is described as follows: ". . . in an interval between the pains . . . two fingers are applied just behind the anus, and forward and upward pressure is made upon the brow through the perinaeum" (Fig. 1). This modified maneuver differed slightly from the original description, which instructed that towel-covered fingers be placed into the rectum. With either, the head is delivered before the next contraction, with the intent of preventing perineal tearing. The modified method was described through the 14th edition of *Williams Obstetrics*, but beginning with the 15th edition,[3] and continuing through today, the Ritgen maneuver is described as being applied during a contraction. Regardless of whether it is applied between or during a contraction, the maneuver undoubtedly has been taught to literally millions of accoucheurs since its description by Ritgen more than 150 years ago.

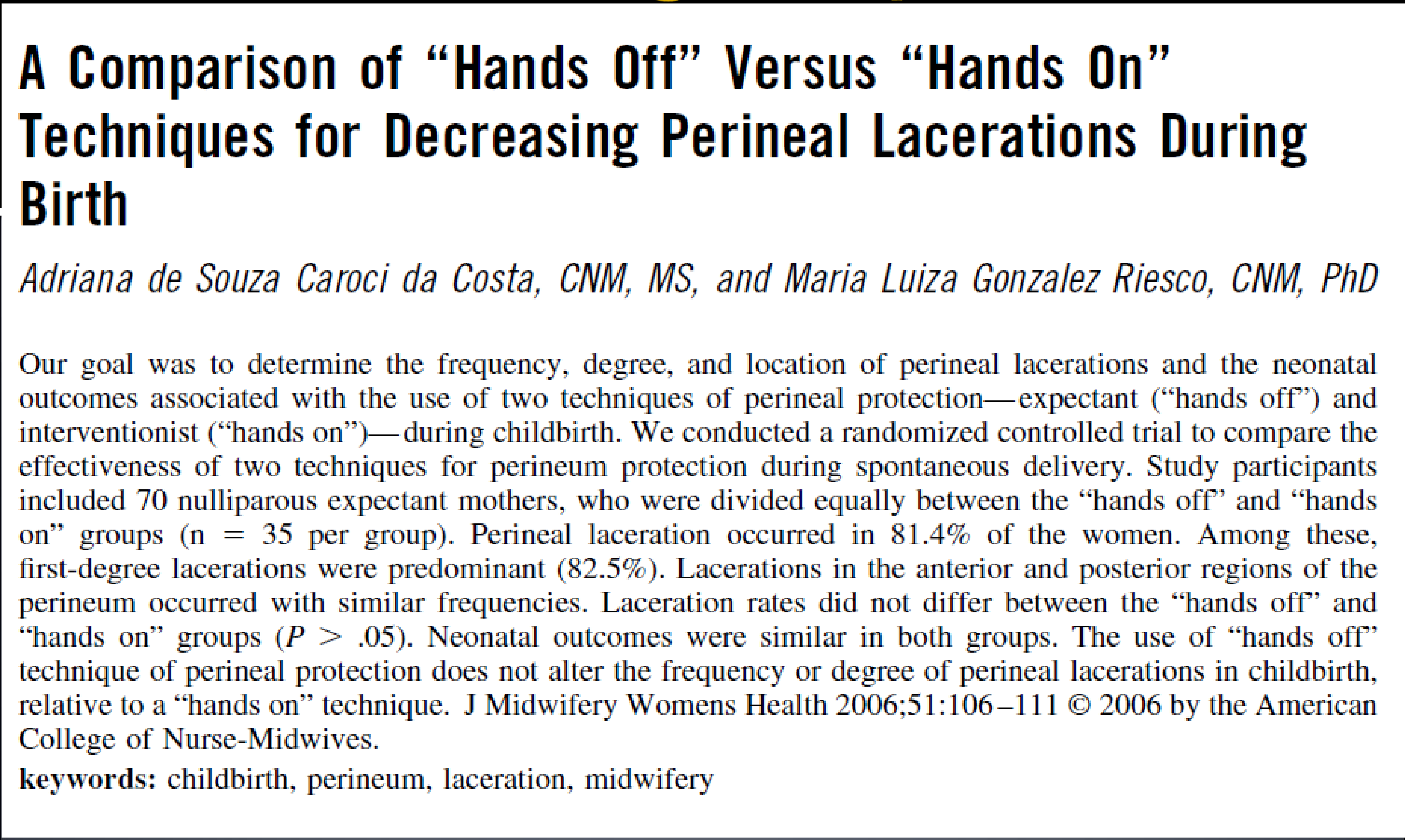
In this issue of *Obstetrics & Gynecology*, Rubin Jönsson and colleagues[4] describe the results of their randomized trial to evaluate the modified Ritgen maneuver, ie, during a contraction, and compared it with simple perineal support to prevent anal sphincter tears. In more than 1,400 nulliparous Swedish women randomized at the beginning of second-stage labor, the authors observed a nonsignificant difference of 5.5% compared with 4.4% sphincter tears with and without performance of the Ritgen maneuver, respectively. These observations are important because they add to the ever-increasing evidence-based outcomes for the practice of obstetrics. At the same time, we must feel some loss of another sacred cow, as most of us were taught the Ritgen maneuver because "we have always done it this way."

Manejo do períneo no parto

- “Para resumir, então: existem aqueles que pressionam o períneo para retardar a deflexão; e aqueles que pressionam para acelerar sua progressão; aqueles que negam que tais efeitos possam ser produzidos; e aqueles que conscientemente usam algum suporte porque acham que alguma coisa tem que ser feita. Mais, aqueles que pressionam a fúrcula; outros que condenam essa manobra e cuidadosamente protegem o períneo posterior; e outros que não tocam o períneo. Além disso, há aqueles que empurram o períneo para trás; e aqueles que, por razões igualmente plausíveis, empurram para frente. Alguns dilatam o esfíncter vaginal; alguns o esfíncter anal. Alguns colocam as suas mãos transversalmente no períneo, outros longitudinalmente, com as mãos espalmadas para cima; alguns longitudinalmente, com as mãos espalmadas para baixo; **alguns atacam o períneo com seus punhos**. Finalmente, há aqueles que usam a mão direita, e aqueles que defendem a mão esquerda. Alguns que advogam uma compressa dobrada; outros uma compressa desdobrada debocham de todas as compressas, dobradas ou desdobradas”

Goodel, W. **A critical inquiry into the management of the perineum during labor**. Am J Med Sci. 61:53, 1871

2.3. Mãos longe do períneo



A Comparison of "Hands Off" Versus "Hands On" Techniques for Decreasing Perineal Lacerations During Birth

Adriana de Souza Caroci da Costa, CNM, MS, and Maria Luiza Gonzalez Riesco, CNM, PhD

Our goal was to determine the frequency, degree, and location of perineal lacerations and the neonatal outcomes associated with the use of two techniques of perineal protection—expectant ("hands off") and interventionist ("hands on")—during childbirth. We conducted a randomized controlled trial to compare the effectiveness of two techniques for perineum protection during spontaneous delivery. Study participants included 70 nulliparous expectant mothers, who were divided equally between the "hands off" and "hands on" groups (n = 35 per group). Perineal laceration occurred in 81.4% of the women. Among these, first-degree lacerations were predominant (82.5%). Lacerations in the anterior and posterior regions of the perineum occurred with similar frequencies. Laceration rates did not differ between the "hands off" and "hands on" groups ($P > .05$). Neonatal outcomes were similar in both groups. The use of "hands off" technique of perineal protection does not alter the frequency or degree of perineal lacerations in childbirth, relative to a "hands on" technique. J Midwifery Womens Health 2006;51:106–111 © 2006 by the American College of Nurse-Midwives.

keywords: childbirth, perineum, laceration, midwifery

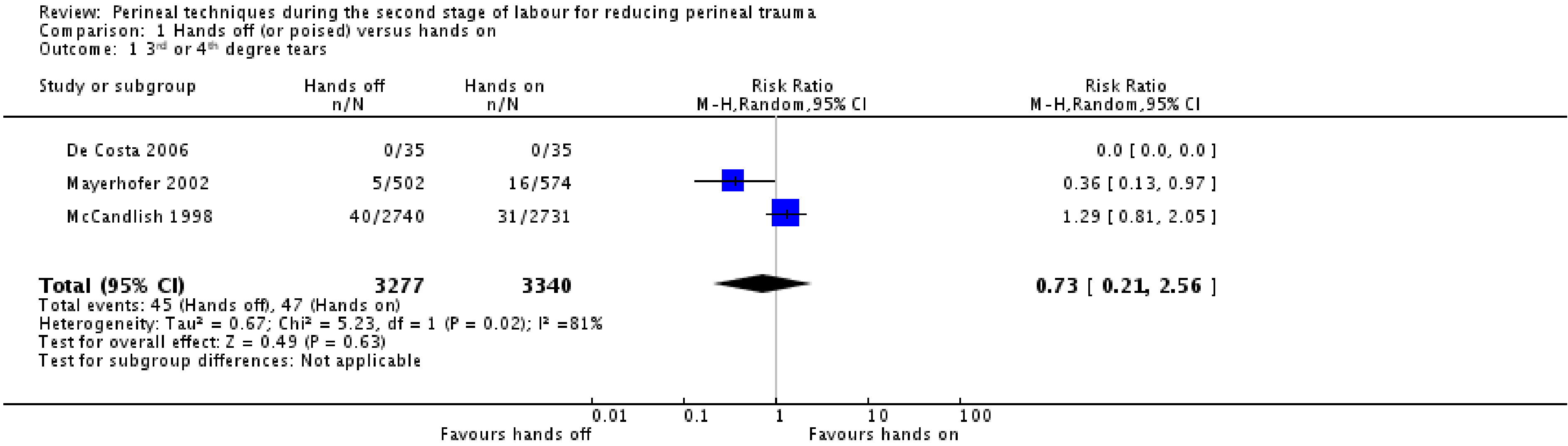
SAFE PACK

Hands-on versus hands-off

Outcome title	No. of studies	No. of participants	Statistical method	Effect size
1 3rd or 4th degree tears	2	1525	Risk Ratio (M-H, Random, 95% CI)	0.48 [0.28, 0.84]
2 Episotomy	2	1525	Risk Ratio (M-H, Random, 95% CI)	0.93 [0.62, 1.39]
3 Intact perineum	2	1525	Risk Ratio (M-H, Random, 95% CI)	1.05 [0.86, 1.26]

Aasheim Vigdis, Nilsen Anne Britt Vika, Lukasse Mirjam, Reinar Liv Merete. **Perineal techniques during the second stage of labour for reducing perineal trauma**. Última atualização: 2011)

Técnicas perineais no segundo período para redução do trauma perineal: hands off (poised)) versus hands on



Review: Perineal techniques during the second stage of labour for reducing perineal trauma
Comparison: 1 Hands off (or poised) versus hands on
Outcome: 1 3^{rd} or 4^{th} degree tears

Study or subgroup	Hands off n/N	Hands on n/N	Risk Ratio M-H,Random,95% CI	Risk Ratio M-H,Random,95% CI
De Costa 2006	0/35	0/35		0.0 [0.0, 0.0]
Mayerhofer 2002	5/502	16/574		0.36 [0.13, 0.97]
McCandlish 1998	40/2740	31/2731		1.29 [0.81, 2.05]
Total (95% CI)	**3277**	**3340**		**0.73 [0.21, 2.56]**

Total events: 45 (Hands off), 47 (Hands on)
Heterogeneity: $\text{Tau}^2 = 0.67$; $\text{Chi}^2 = 5.23$, df = 1 (P = 0.02); $I^2 = 81\%$
Test for overall effect: Z = 0.49 (P = 0.63)
Test for subgroup differences: Not applicable

Aasheim Vigdis, Nilsen Anne Britt Vika, Lukasse Mirjam, Reinar Liv Merete. **Perineal techniques during the second stage of labour for reducing perineal trauma**. Cochrane Database of Systematic Reviews. In: *The Cochrane Library*, Issue 9, Art. No. CD006672. DOI: 10.1002/14651858.CD006672.pub12 (última atualização 2011)

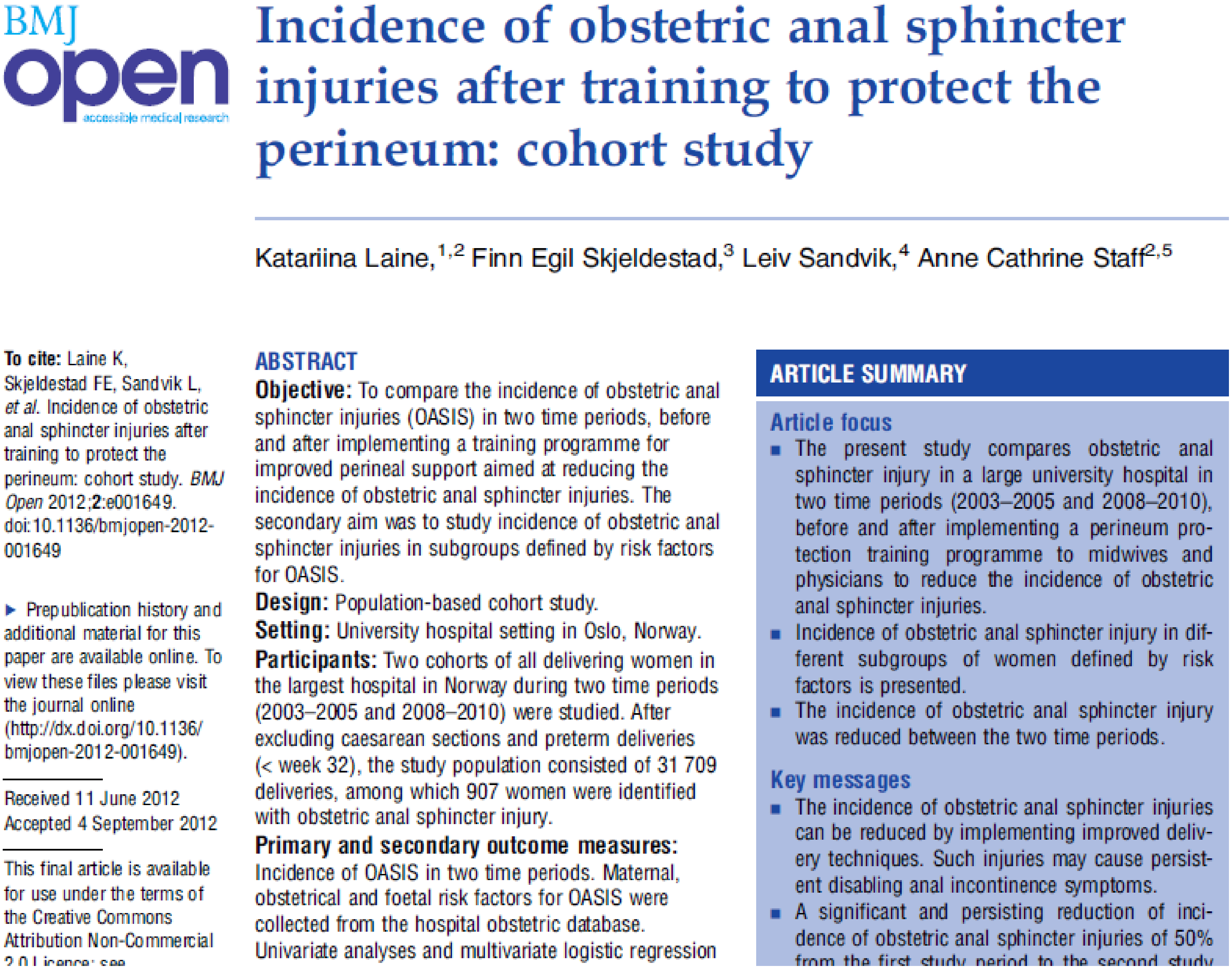
Algo mais poderia ser feito?

Ou deixar de ser feito

2.4. Compressa morna versus controle (hands off ou sem compressa)

Outcome title	No. of studies	No. of participants	Statistical method	Effect size
1 3rd or 4th degree tears	2	1525	Risk Ratio (M-H, Random, 95% CI)	0.48 [0.28, 0.84]
2 Episotomy	2	1525	Risk Ratio (M-H, Random, 95% CI)	0.93 [0.62, 1.39]
3 Intact perineum	2	1525	Risk Ratio (M-H, Random, 95% CI)	1.05 [0.86, 1.26]

Aasheim Vigdis, Nilsen Anne Britt Vika, Lukasse Mirjam, Reinar Liv Merete. **Perineal techniques during the second stage of labour for reducing perineal trauma**. Última atualização: 2011)



BMJ open
accessible medical research

Incidence of obstetric anal sphincter injuries after training to protect the perineum: cohort study

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ABSTRACT

Objective: To compare the incidence of obstetric anal sphincter injuries (OASIS) in two time periods, before and after implementing a training programme for improved perineal support aimed at reducing the incidence of obstetric anal sphincter injuries. The secondary aim was to study incidence of obstetric anal sphincter injuries in subgroups defined by risk factors for OASIS.

Design: Population-based cohort study.

Setting: University hospital setting in Oslo, Norway.

Participants: Two cohorts of all delivering women in the largest hospital in Norway during two time periods (2003–2005 and 2008–2010) were studied. After excluding caesarean sections and preterm deliveries (< week 32), the study population consisted of 31 709 deliveries, among which 907 women were identified with obstetric anal sphincter injury.

Primary and secondary outcome measures: Incidence of OASIS in two time periods. Maternal, obstetrical and foetal risk factors for OASIS were collected from the hospital obstetric database. Univariate analyses and multivariate logistic regression

ARTICLE SUMMARY

Article focus

- The present study compares obstetric anal sphincter injury in a large university hospital in two time periods (2003–2005 and 2008–2010), before and after implementing a perineum protection training programme to midwives and physicians to reduce the incidence of obstetric anal sphincter injuries.
- Incidence of obstetric anal sphincter injury in different subgroups of women defined by risk factors is presented.
- The incidence of obstetric anal sphincter injury was reduced between the two time periods.

Key messages

- The incidence of obstetric anal sphincter injuries can be reduced by implementing improved delivery techniques. Such injuries may cause persistent disabling anal incontinence symptoms.
- A significant and persisting reduction of incidence of obstetric anal sphincter injuries of 50% from the first study period to the second study

Puxos no período expulsivo

Effect of spontaneous pushing versus Valsalva pushing in the second stage of labour on mother and fetus: a systematic review of randomised trials

BJOG. 2011 May;118(6):662-70. doi: 10.1111/j.1471-0528.2011.02910.x. Epub 2011 Mar 10

Resultado	Impacto do resultado
Duração do segundo período	Valsalva: 18,59 minutos a menos
Parto instrumental operatório	Não houve diferenças
pH arterial < 1,20	Não houve diferenças
Apgar < 7 no 5’ minuto	Não houve diferenças

Puxo espontâneo versus puxo com manobra de Valsalva

- As evidências de nossa revisão não suportam o uso de rotina da manobra de Valsalva durante o segundo período do TP. De acordo com um estudo, a manobra de Valsalva teve efeitos negativos sobre fatores urodinâmicos. Encorajar o puxo espontâneo e encorajar a mulher a escolher seu próprio método de puxar parece ser a melhor prática

Effect of spontaneous pushing versus Valsalva pushing in the second stage of labour on mother and fetus: a systematic review of randomised trials BJOG. 2011 May;118(6):662-70. doi: 10.1111/j.1471-0528.2011.02910.x

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery

Antes de diagnosticar parada de progressão no segundo período, se as condições maternas e fetais forem boas, permitir o seguinte

- Pelo menos 2 horas de puxo em multíparas
- Pelo menos 3 horas de puxo em nulíparas

Durações maiores podem ser apropriadas em base individual (uso de peridural, ou posição fetal, desde que haja progressão do parto)

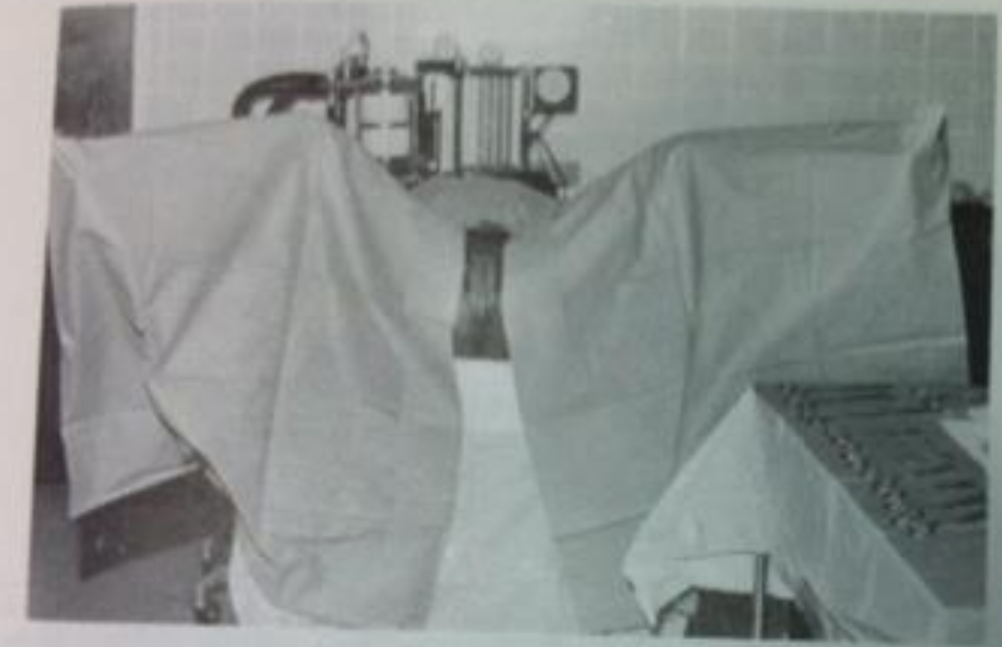

FIGURE 13-3. Following thorough scrubbing of the vulva, perineum, and adjacent regions, the field is sterile-draped in preparation for delivery.

later in the chapter, the perineum by now is extremely thin and, especially in the case of the nulliparous woman, may undergo spontaneous laceration. At the same time, the anus becomes greatly stretched and protuberant, and the anterior wall of the rectum may be easily seen through it. Over many years there has been considerable controversy concerning whether an episiotomy should be cut. We advocate individualization and do not routinely cut an episiotomy. It is now clear that an episiotomy will increase the risk of a tear into the external anal sphincter and/or the rectum. Conversely, anterior tears involving the urethra and labia are much more common in women in whom an episiotomy is not cut. This is discussed in detail on page 325.

RITGEN MANEUVER. By the time the head distends the vulva and perineum (during a contraction) enough to open the vaginal introitus to a diameter of 5 cm or more, a towel-draped, gloved hand may be used to exert forward pressure on the chin of the fetus through the perineum just in front of the coccyx. At the same time, the other hand exerts pressure superiorly against the occiput (Fig. 13–6). Although this maneuver is simpler than that originally described by Ritgen (1855), it is

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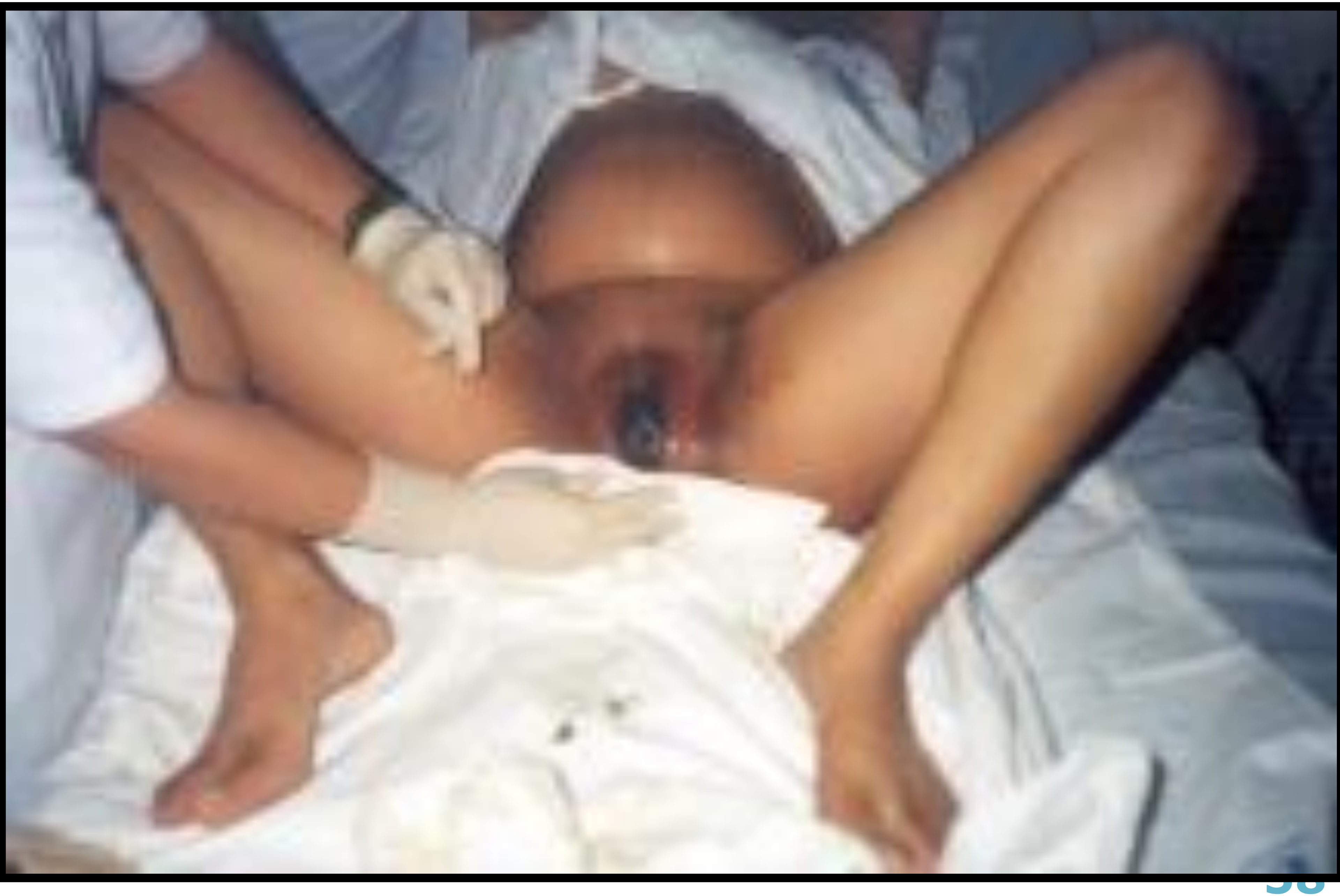
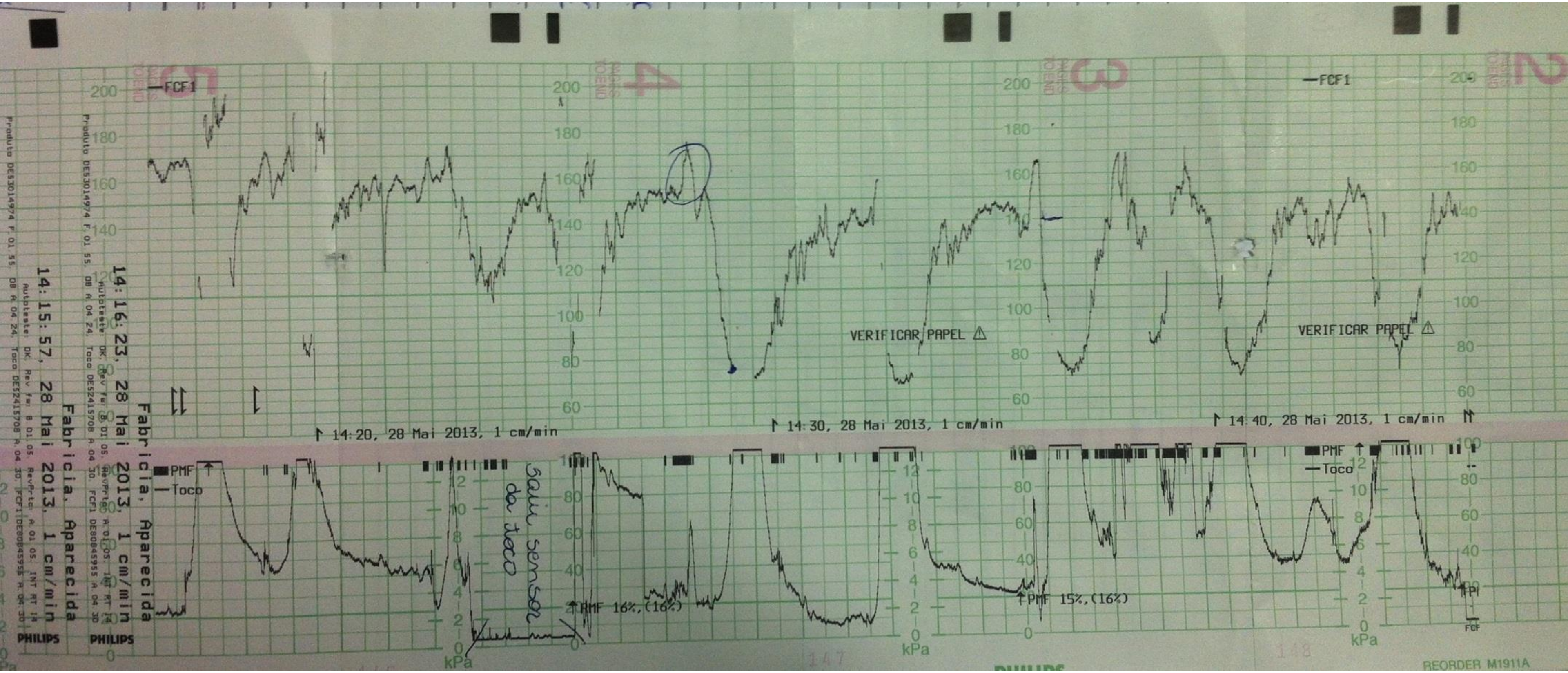
PREVINA-SE



BCF de 5/5 minutos ou após cada contração

SAFE PACK

Joana, 34 anos, G2Pn1, gestação 39 + 5, admitida em TP espontâneo às 8:30. Ás 14:30, colo 8 cm, 80%, plano 0/+1, OEA, bolsa rota, líquido claro. Pré-natal de risco habitual. AU = 35 cm


FCF1
200
180
160
140
120
100
80
60
14: 15: 57, 28 Mai 2013, 1 cm/min
14: 16: 23, 28 Mai 2013, 1 cm/min
Fabricia, Aparecida
14: 20, 28 Mai 2013, 1 cm/min
14: 30, 28 Mai 2013, 1 cm/min
14: 40, 28 Mai 2013, 1 cm/min
VERIFICAR PAPEL ⚠
PMF
Toco
PMF 16%, (16%)
PMF 15%, (16%)
kPa
saiu sensor do toco
PHILIPS
REORDER M1911A

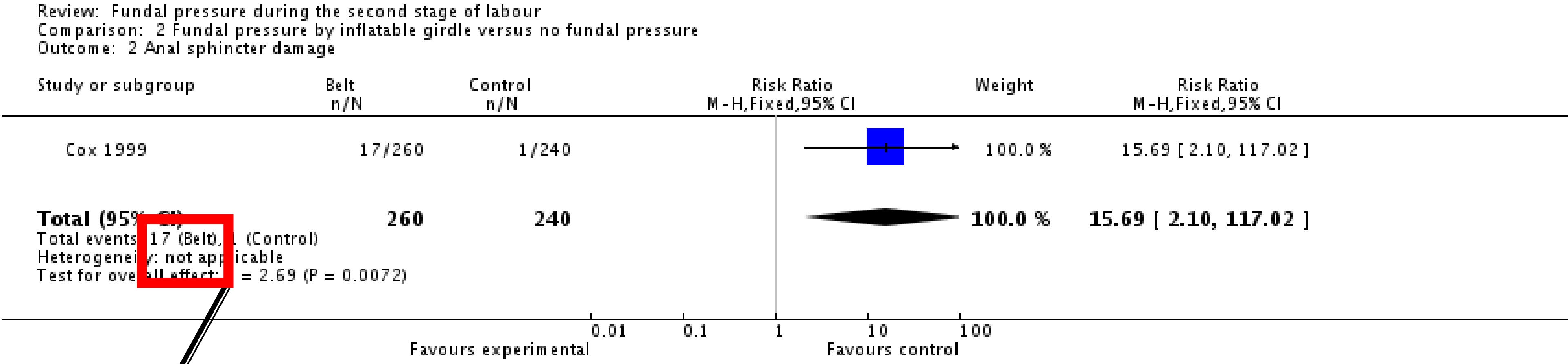
13TH ANNUAL
LAIRD WILSON JR. PHD SYMPOSIUM

Oxytocin: One of the 10 most dangerous drugs!

Heidi Leftwich, DO
Maternal-Fetal Medicine Fellow
Obstetrics & Gynecology
University of Illinois Hospital & Health Sciences System

AT THE UNIVERSITY OF ILLINOIS AT CHICAGO
FRIDAY, OCTOBER 25, 2013

Pressão no fundo uterino durante o segundo período do TP – Trauma no esfíncter anal



Review: Fundal pressure during the second stage of labour
Comparison: 2 Fundal pressure by inflatable girdle versus no fundal pressure
Outcome: 2 Anal sphincter damage

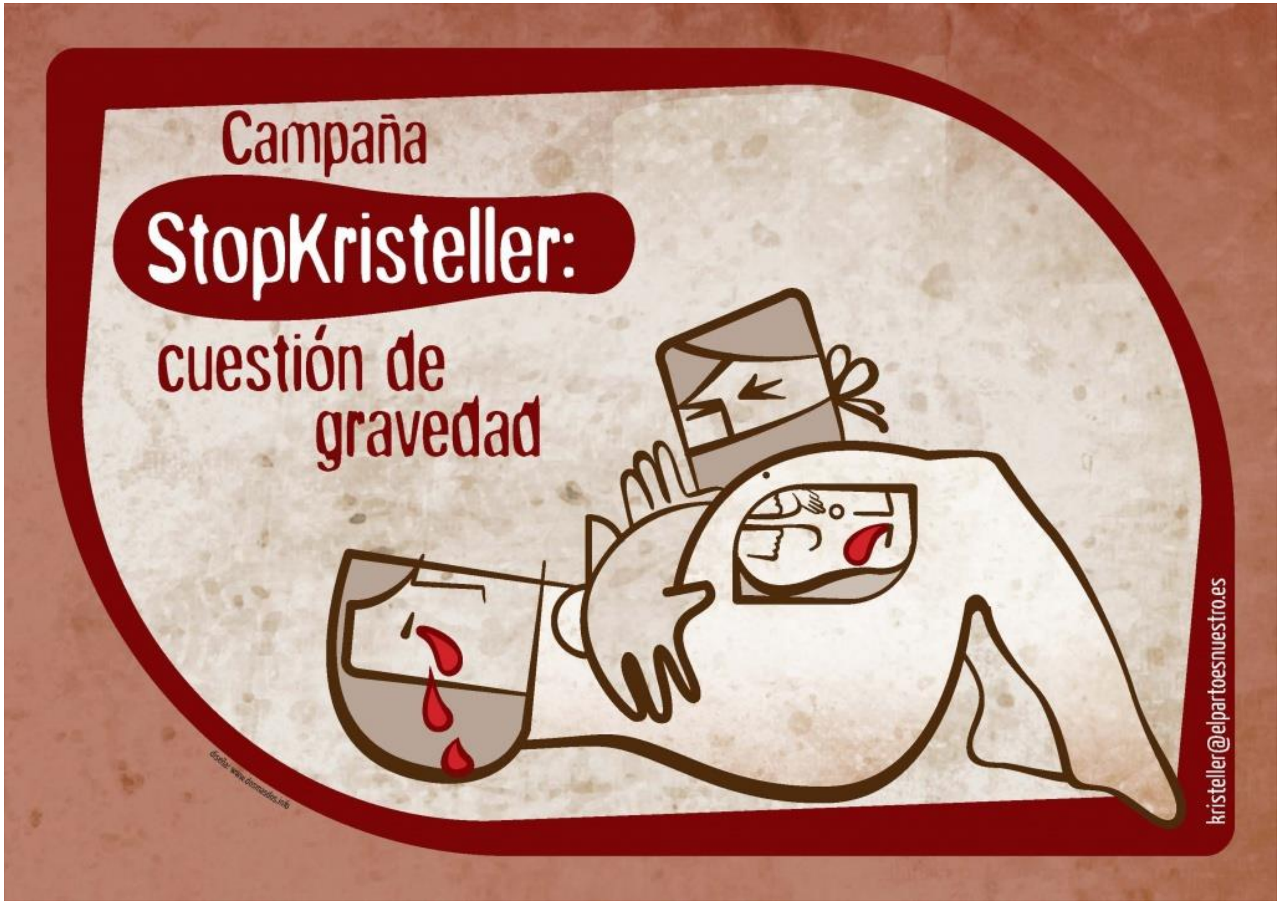
Study or subgroup	Belt n/N	Control n/N	Risk Ratio M-H,Fixed,95% CI	Weight	Risk Ratio M-H,Fixed,95% CI
Cox 1999	17/260	1/240		100.0 %	15.69 [2.10, 117.02]
Total (95% CI)	**260**	**240**		**100.0 %**	**15.69 [2.10, 117.02]**

Total events: 17 (Belt), 1 (Control)
Heterogeneity: not applicable
Test for overall effect: = 2.69 (P = 0.0072)

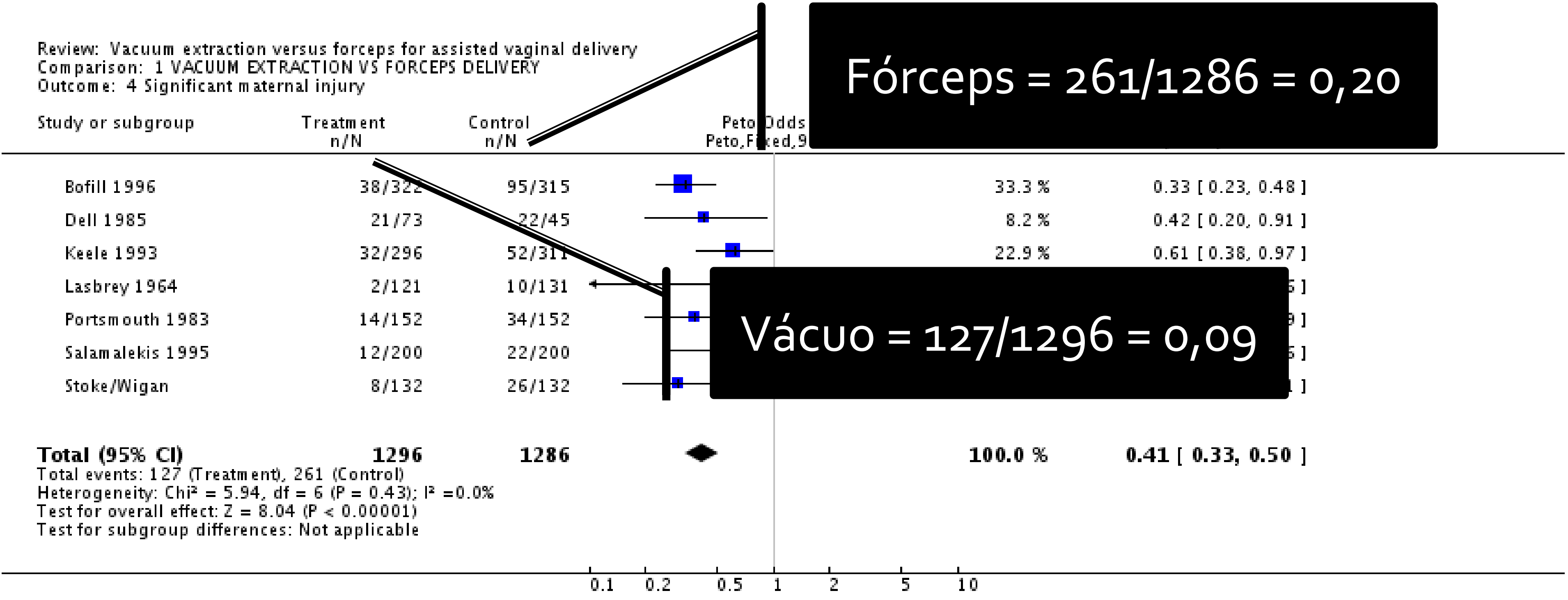
17/260 = 6,5%

Verheijen Evelyn C, Raven Joanna H, Hofmeyr G Justus. **Fundal pressure during the second stage of labour**. Cochrane Database of Systematic Reviews. In: *The Cochrane Library*, Issue 5, Art. No. CD006067. DOI: 10.1002/14651858.CD006067.pub4

Samuel Kristeller, 1820-1900


Campaña
StopKristeller:
cuestión de gravedad
kristeller@elpartoesnuestro.es
diseño: www.dosmasdos.info

Vácuo-extração versus fórceps para parto vaginal assistido – lesão materna importante



Fórceps = 261/1286 = 0,20

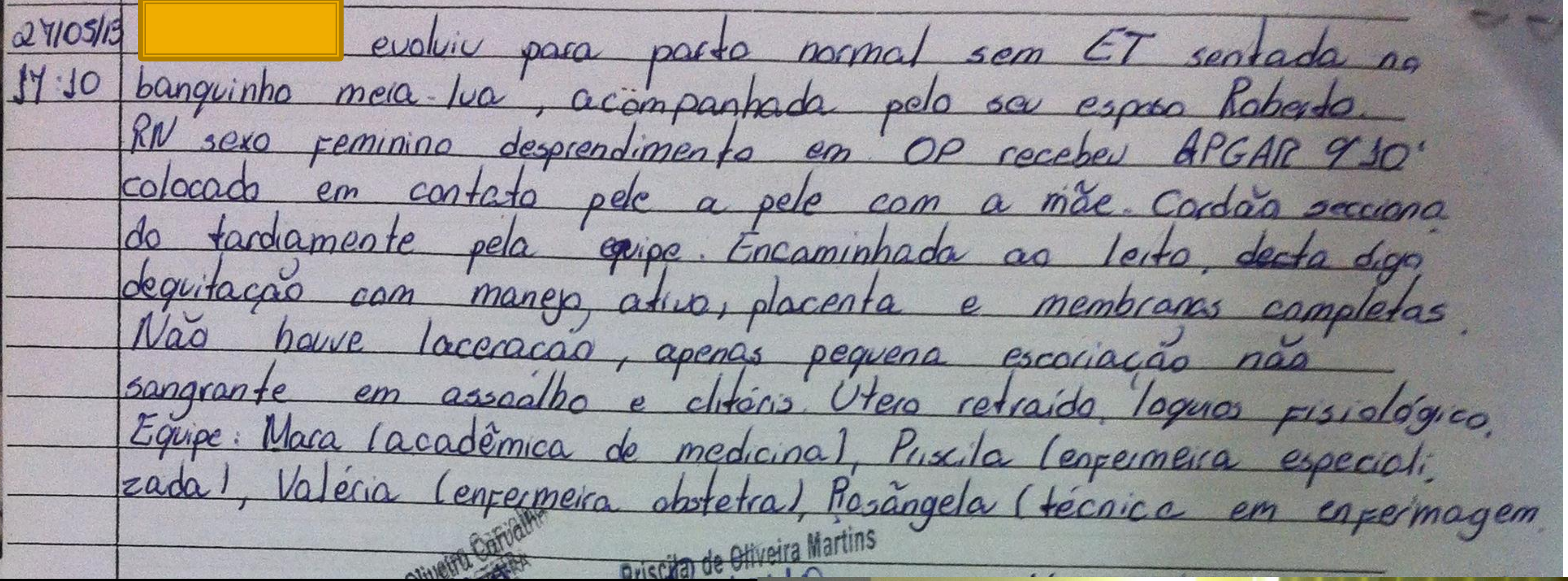
Vácuo = 127/1296 = 0,09

Review: Vacuum extraction versus forceps for assisted vaginal delivery
Comparison: 1 VACUUM EXTRACTION VS FORCEPS DELIVERY
Outcome: 4 Significant maternal injury

Study or subgroup	Treatment n/N	Control n/N	Peto Odds Peto,Fixed,9		
Bofill 1996	38/322	95/315		33.3 %	0.33 [0.23, 0.48]
Dell 1985	21/73	22/45		8.2 %	0.42 [0.20, 0.91]
Keele 1993	32/296	52/311		22.9 %	0.61 [0.38, 0.97]
Lasbrey 1964	2/121	10/131			5]
Portsmouth 1983	14/152	34/152			9]
Salamalekis 1995	12/200	22/200			5]
Stoke/Wigan	8/132	26/132			1]
Total (95% CI)	**1296**	**1286**		**100.0 %**	**0.41 [0.33, 0.50]**

Total events: 127 (Treatment), 261 (Control)
Heterogeneity: Chi² = 5.94, df = 6 (P = 0.43); I² =0.0%
Test for overall effect: Z = 8.04 (P < 0.00001)
Test for subgroup differences: Not applicable

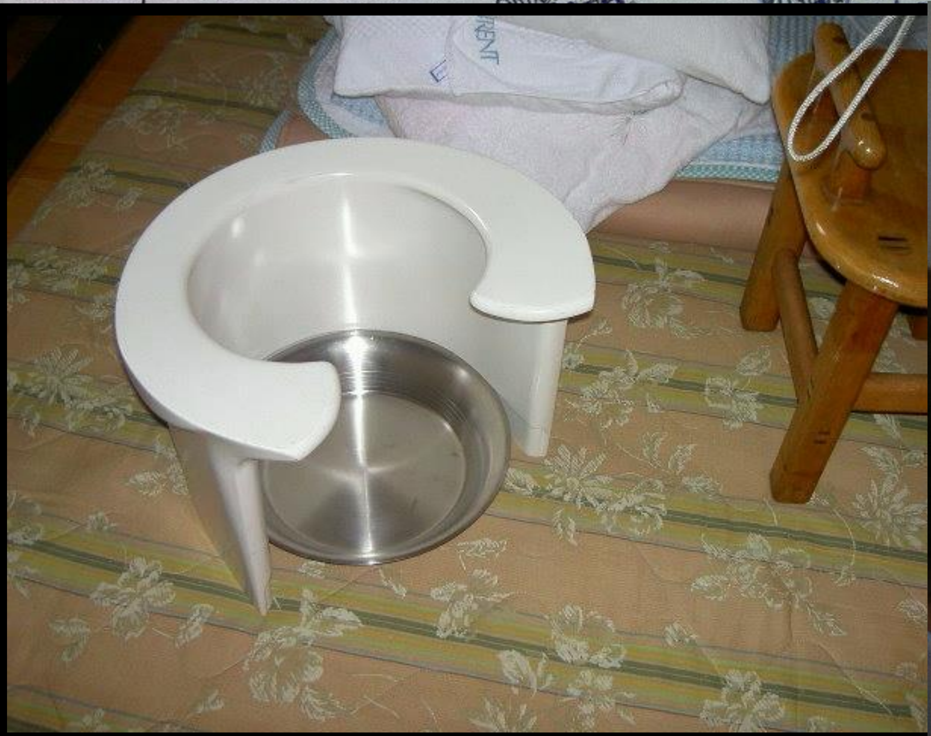
Johanson Richard, Menon Vijay. **Vacuum extraction versus forceps for assisted vaginal delivery**. Cochrane Database of Systematic Reviews. In: *The Cochrane Library*, Issue 5, Art. No. CD000224. DOI: 10.1002/14651858.CD000224.pub3



27/05/13 [redacted] evoluiu para parto normal sem ET sentada no
17:10 banquinho meia-lua, acompanhada pelo seu esposo Roberto.
RN sexo feminino desprendimento em OP recebeu APGAR 9/10'
colocado em contato pele a pele com a mãe. Cordão seccionado tardiamente pela equipe. Encaminhada ao leito, decta digo
dequitação com manejo ativo, placenta e membranas completas.
Não houve laceração, apenas pequena escoriação não
sangrante em assoalho e clitóris. Útero retraído, loquios fisiológico.
Equipe: Mara (acadêmica de medicina), Priscila (enfermeira especializada), Valéria (enfermeira obstetra), Rosângela (técnica em enfermagem

Oliveira Carvalho

Priscila de Oliveira Martins



SIM, É POSSÍVEL

OBRIGADO!!!!!!!!!!!!!