Reviewer’s report

Title: A novel classification for evaluating episiotomy practices: application to the Burgundy perinatal network.

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Reviewer: Zdenek Rusavy

Reviewer’s report:

Thank you for allowing me to review this manuscript. Desplanches et al. propose a classification of vaginal deliveries according to the possible risk of performing an episiotomy (parity, singleton/multiple gestations, presentation and mode of delivery). They then perform an audit of episiotomy use and OASI prevalence in the maternity units in Burgundy Perinatal Network.

A very similar classification has ben proposed by Robson, originally for cesarean sections, but frequently used for classification of vaginal deliveries as well. Such classification is certainly useful for evaluation of episiotomy rates in high-risk and low-risk groups and comparison among the maternity hospitals. However, why not use the Robson classification for this purpose? It has already been adopted in numerous maternity units and in many (including ours), it is used used for classification of vaginal deliveries as well. What does this novel classification add to the current one? I believe that if such classification was intended for reduction of unnecessary episiotomy, it should contain a subcategory of fetal distress (decelerations with/without meconium stained amniotic fluid, bradycardia, non-reassuring/abnormal CTG), where episiotomy is frequently indicated to hasten the delivery.

I disagree with the term classification of episiotomy as this classification is called by the authors. An episiotomy can by classified by type (median/mediolateral/lateral, etc.), timing (before crowning/ at crowning) or even indication (hypoxia, instrumental delivery, expected macrosomy). This classification does not describe the procedure and indeed the authors are using it for evaluation of OASI.

I would like to read more about the practice of primary perineal trauma prevention in the BPN. The authors are searching for association between episiotomy practice and OASI, however, how about the other practices, e.g. manual perineal protection? Is it performed routinely? Is it performed properly? Is it performed also with episiotomy or instrumental delivery? There are many confounders that should be explained or at least discussed.

The main objective of the article is unclear to me. Is it an audit of episiotomy or analyzing risk factors of OASI and the role of episiotomy in their prevention? The two topics seem to run in parallel depriving the manuscript of one clear message. From the description of the objective as it is stated in the abstract, it is unclear to me how do the authors intend to describe incidence of OASI by classification of episiotomies.
The manuscript does not follow the author guidelines and format of the journal (subheadings, tables in text, etc.).

One of the main results of the audit is the protective role of episiotomy in instrumental deliveries, this is in agreement with other recently published data suggesting that episiotomy should be performed routinely in instrumental delivery. This deserves broader discussion.

In my opinion, this manuscript would be much better as an audit of episiotomy use and its effect on OASI using and existing classification (Robson).

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Unable to assess

Are the conclusions drawn adequately supported by the data shown?
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Yes

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I am able to assess the statistics

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