**MATERNITY UNIT**

**GUIDELINE:** Perineal Trauma and Repair

**SCOPE**: All midwives and obstetricians working in the maternity unit.

**AUTHOR:** Midwifery Educator & Quality Coordinator

**PURPOSE:** To give guidance on the repair of perineal trauma following childbirth.

**DEFINITIONS:**
Trauma to the perineum can be anterior (involving the labia, urethra, clitoris or anterior vaginal wall) or posterior (involving the posterior vaginal wall, perineal muscles or anal sphincters).

Tears can be defined as:

**First degree tear** – involves the skin only of the fourchette or labia.

**Second-degree tear** (also episiotomy) – is injury to the perineum and/or vagina as well as the fourchette. It involves the perineal muscle but NOT the anal sphincter muscles. The perineal muscles which may be damaged are the superficial bulbocavernosus and transverse perineal muscle. The deep pubococcygeus is also affected in some severe tears.

**Third degree tear** – is injury to the perineal body and the internal (IAS) and external (EAS) anal sphincter. It is categorised into the following:

3a. Less than 50% of EAS thickness torn
3b. More than 50% of EAS thickness torn
3c. IAS torn

**Fourth degree tear** – injury to the perineum involving the anal sphincter muscles, both internal and external, and the anal epithelium.

Trauma to the vagina and/or cervix warrants immediate attention and repair due to the risk of heavy bleeding and/or infection.

**GUIDELINE:**
Most women will experience some degree of perineal trauma during childbirth, some of which will require repair. Consequently, midwives must be proficient in the prevention, recognition and optimum repair of perineal trauma.

<u>Preventing perineal trauma:</u>
Employing methods to reduce the risk of perineal trauma and its associated morbidity is an important role for the midwife. There is solid evidence to suggest that a woman will benefit from performing antenatal perineal massage regularly from about 36 weeks gestation.

Midwifery practice during the second stage of labour has a significant impact on the risk of perineal damage sustained by women. Limiting the duration of the second stage in a 'low risk' labour may not allow physiological changes to take place in the perineal tissues, and may result in an increased risk of damage.

To enable the woman to move freely and take a position of choice during the second stage reflects supportive midwifery care and may have a significant impact on the integrity of the perineum at birth. Waterbirth has been found to reduce the likelihood of serious perineal trauma and recommends a 'hands off' approach as the volume of water supports the perineum.

The application of Warm compresses, during the second stage of labour has been found to reduce the risk of obstetric and anal sphincter injuries (OASIS). Oils and perineal massage may help alleviate discomfort during the process, but it is only the massage that has been shown to reduce the risk of third and fourth degree tears.

Gently supporting the fetal head during crowning and perineal protection is also considered to reduce perineal trauma.

To suture or not to suture:

There appears to be very little difference in the postnatal morbidity experienced by women who have experienced first and minor second degree perineal lacerations, whether sutures are used or not. Some authors advocate the practice of leaving second-degree tears unsutured if there is no bleeding evident. However, if the laceration is significant and is not sutured this can lead to both short and long term morbidity.

The decision not to suture may result in infection, poor healing and skin tags.

The inappropriate use of sutures can also create problems for the woman. There can be pain during intercourse, incontinence of urine and/or faeces or even prolapse of organs supported by the pelvic floor. These problems are likely to lead to long-term physical, psychological and social morbidity. In some cases surgery is needed to correct poorly stitched tissue.

So when is it safe practice to leave the perineal laceration unsutured? Some suggestions are:

- First degree tear of fourchette (i.e. skin tear only)
- 'Minor' second degree tears which are not bleeding or where any bleeding is easy to stop. This type of tear will normally involve a minor portion of the bulbocavernosus only, but this decision must be made with the woman and documented if the decision not to suture is made.
- Labial trauma with no bleeding. Labial lacerations can be quite painful but management can be limited to good hygiene and analgesia. It is often not possible to suture these tears as there is no substantial flesh to bite into.

If the midwife is uncertain about the type or severity of the tear she should seek a second opinion from another more experienced midwife, or an obstetrician.

A laceration that is found to be 3rd or 4th degree tear and/or involves the urethra or cervix, should always be referred to and repaired by an experienced obstetrician. The repair will normally take place in theatre with a regional analgesia ie spinal anaesthetic insitu but may be performed in the birthing room. The decision will be made following a 4 way conversation and recorded in the records. If the repair takes place in theatre it is the obstetrician's responsibility to arrange this. If in the birthing room, the obstetrician will collect the repair pack and consumables from theatre and the midwife will prepare the woman ensuring she is comfortable and bed linen is changed.

Postnatal care following a 3rd or 4th degree tear will include antibiotics, analgesia, aperients, referral to the physio and a 6 week follow up appointment with the obstetrician. All cases of 3rd and 4th degree tears require a thorough documentation (Appendix One) by the obstetrician and midwives providing care to this woman during labour and postnatally.

Complications of a perineal trauma can include infection, fistula, incontinence of faeces and fusing together of the labia.

Technique:

Perineal repair preparation:

- Repair should be carried out as soon as possible due to bleeding and formation of oedema. Midwives should however be aware of the need for skin-to-skin contact of mothers and their newborn babies and be able to facilitate this process whilst appreciating the need for suturing.
- Using an aseptic technique lay out the instruments required. These will include sterile gloves, 20ml syringe and 22 gauge (black) needle, 20ml Lignocaine 1%, sutures which may be sizes 2/0 or 3/0) of Vicryl or Vicryl Rapide with curved needle (polyglycolic acid sutures are known to minimise pain felt by the woman), needle holder, tissue forceps and scissors. A vaginal pack, gauze swabs (counted) and a sterile drape.
- If an epidural has been used, wait for the top up to take effect.
- Good lighting is essential.
- The woman should either lie comfortably at the end of the bed with legs on rests, or in the lithotomy position. Be aware that this position holds an increased risk of DVT.

Perineal repair technique:

- Wash the vulval area (tap water may be used for this purpose) and perform a full inspection of the trauma including a rectal examination to exclude a 3rd or 4th degree tear. Tap water can be used for this purpose, change your gloves and then position a sterile drape if used.
- Consider placing a pack in the vagina to stem the flow of lochia, and secure the tape to the drape.
- Examine the tear once again to check severity and discuss the method of repair with the woman.
- Draw up Lignocaine with the assistance of another person to maintain sterility - a total dose of 20ml of 1% Lignocaine can be infiltrated into the perineum. *If the woman had a local anaesthetic prior to an episiotomy, then this amount should be included in the total amount given.*
- Inject into tissue using following technique (entonox should be offered to the woman for this procedure):
    1. Enter at one side of tear at the fourchette and push the needle towards the apex of the tear in the vagina.
    2. Check for vessel puncture and then slowly withdraw needle whilst infiltrating.
    3. Without removing the needle from the skin, point down, on the same side, to the end of the tear in perineum.
    4. Repeat infiltration.
    5. Repeat on the other side of the tear and wait three or four minutes for anaesthetic to take effect.

Suturing is done in three stages: vagina, perineal muscles and then the skin.

- Starting just beyond the apex of the vaginal tear, take a bite of tissue of about ½ cm on either side. Tie using a square knot initially with two throws followed by one and one to secure.
- Use a continuous running (not locked) suture technique that is not too tight, down the length of the tear. Take care at the fourchette so tissue is brought together correctly.
- At the hymenal ring take the needle through the vaginal wall and bring it out in the perineal muscle layer.
- Use continuous suturing in the deep tissue of the perineum ending with the needle in the subcutaneous layer at the anal margin of the tear or episiotomy. This is a preferred method due to the reduced pain felt by woman in the postnatal period. However, interrupted stitches may be used taking care not to leave any 'dead space' where a haematoma can develop. **The technique used in this deep layer of the perineum influences the strength of the pelvic floor.**
- The skin of the perineum is then drawn together using subcuticular stitches. This method reduces short-term problems such as pain and dyspareunia. (There is evidence to suggest that this skin layer can be left without sutures.)
- Starting at the bottom of the wound take a small bite of skin on one side and another at the same level on the other side, continue to take bites of skin on alternate sides without tension, until the skin edges are loosely approximated.
- At the fourchette take the needle behind the hymenal ring so the needle comes out into the posterior vaginal wall. Use an Aberdeen knot to tie off so there is only one thread in the vagina.
- It is important not to make any of the sutures too tight, as oedema will occur in the first 24/48 hours.

Following suturing:
When suturing is complete, remove vaginal pack if used, check needles, swabs and instruments, and examine the rectum to detect whether any sutures have involved the rectal tissue.

- Analgesic suppositories may be used e.g. Paracetamol 1g and/or Voltaren 100mg.
- Provide basic care with sanitary protection and comfort measures e.g. cool pads
- The use of a wrapped ice pack applied to the perineum for 10 minutes has been shown to be effective for perineal pain relief after vaginal birth.
- Provide advice to the woman on the degree of the tear and the healing process, discuss perineal hygiene and recommend she parts her labia daily to avoid fusion of the tissue if labial tears present, the importance of drinking plenty of fluids and having a healthy nutritional diet and pelvic floor exercises to promote healing.
- Document that suturing has been performed in the perineal repair form in MCIS ensuring all sections are fully completed: perineal repair, post suturing, swab and needle check. Ensure a postnatal management plan is completed by the practitioner completing the repair and record tasks if any are required (ie follow-up appointments required, referrals required etc) – see appendix one for examples of documentation.
- Ongoing perineal condition should be monitored and documented until healing has occurred. Observe for any pain, swelling, signs of infection and incontinence, and manage/refer appropriately.

- During postnatal examination gain consent to inspect the perineal repair and any unsutured trauma and explain the importance of doing so.
- Physio referral for 3rd and 4th degree tears and O&G follow up.
- A 3rd or 4th degree tear is not an indicator for having an elective LSCS with any future births, however the risks of further perineal or rectal damage at subsequent births needs to be discussed and documented preferably by an obstetrician.
- Women may be eligible for ACC if a 3rd or 4th degree tear was sustained following an episiotomy or instrumental birth – see appendix two.
- Offer information during the postnatal period on when to resume sexual intercourse. If she sustained an episiotomy this time she should be advised that she will not necessarily require a repeat one for the next birth. Ensure the woman is aware of the degree of trauma she sustained and any complications which may have occurred associated with the perineal trauma and answer any questions she may have. Women may experience feelings of altered body image following perineal trauma, it is important to address these issues early with follow up with the obstetrician if the woman desires. Also consider referral to the Health Physiotherapist if any concerns or prolonged perineal discomfort.

**EVALUATION METHOD**

Documentation of suturing of perineal trauma will be randomly audited. Any problems with perineal repair or subsequent concerns will be reported and discussed at the weekly maternity unit meetings.

**ASSOCIATED DOCUMENTS**

Organisational Breastfeeding Policy
Maternity - Performing an episiotomy
Maternity – 3rd & 4th degree perineal repair care pathway

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**Authorised By (HOD Obstetrics)**

**Authorised by (Director of Midwifery/Clinical Midwifery Manager)**

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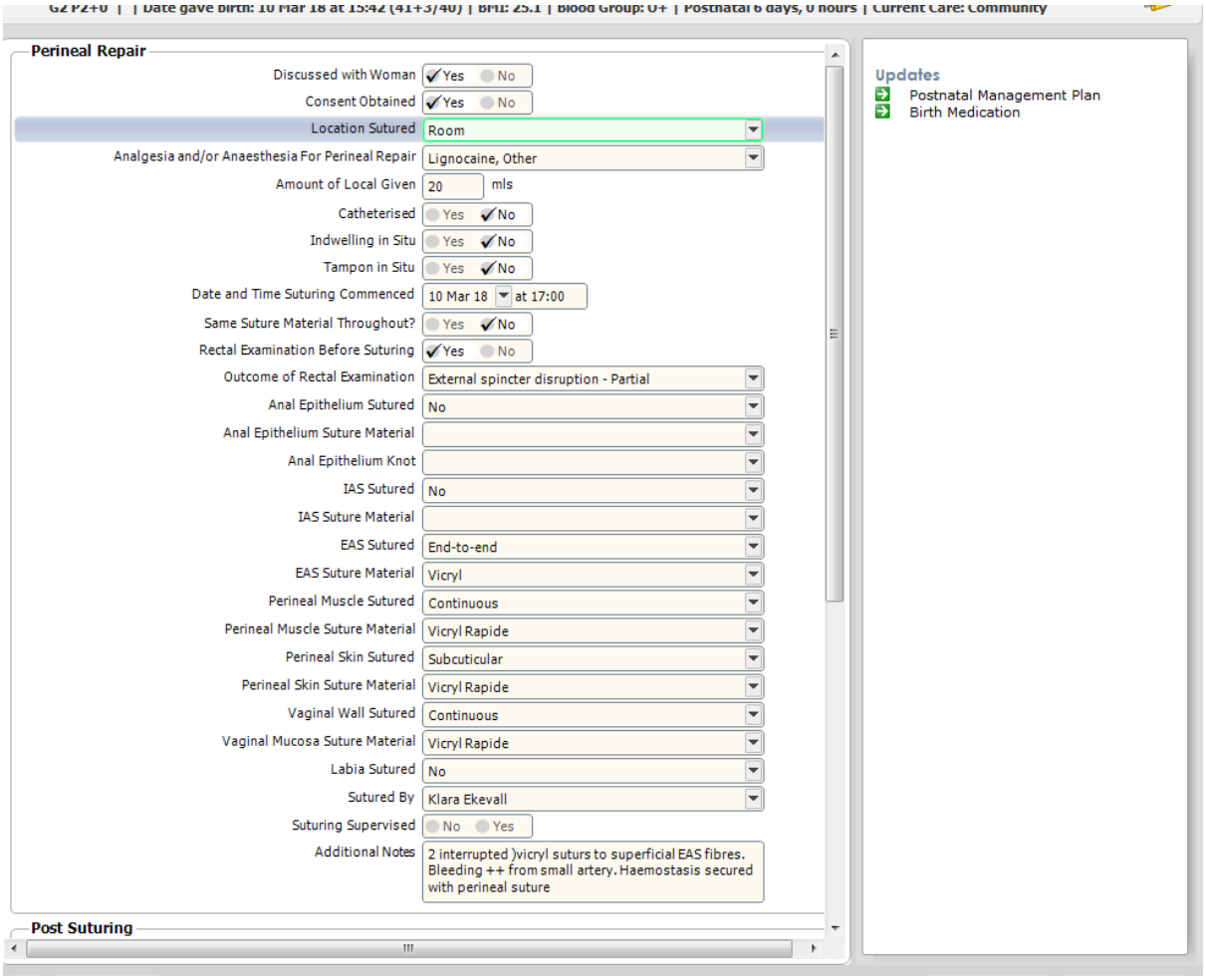
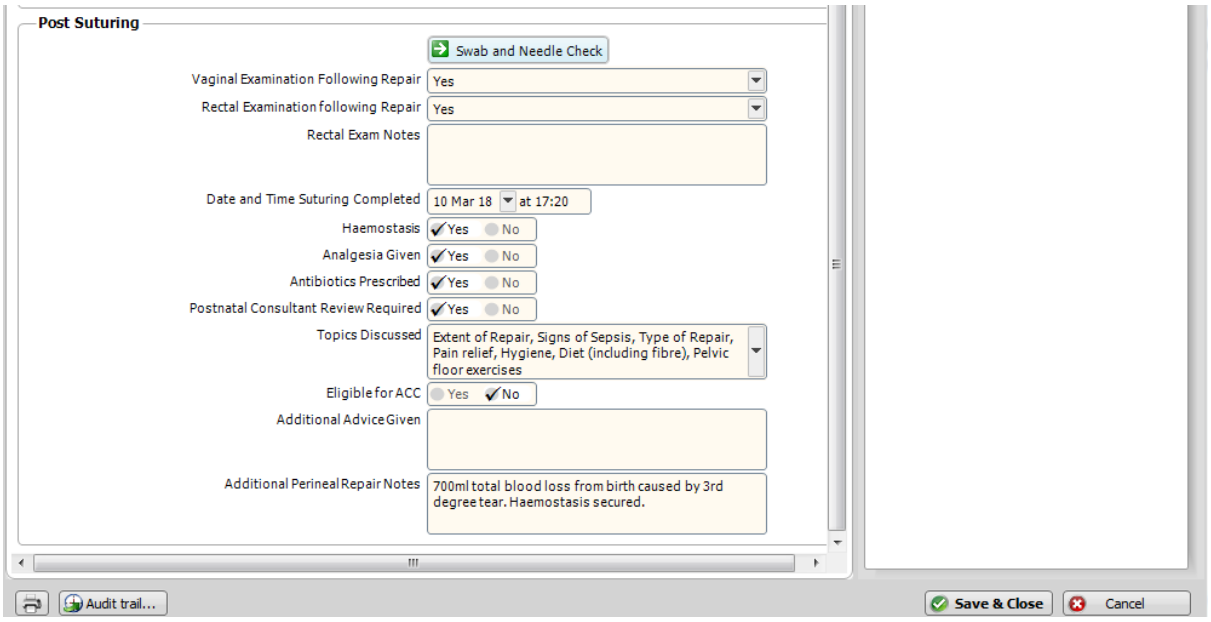
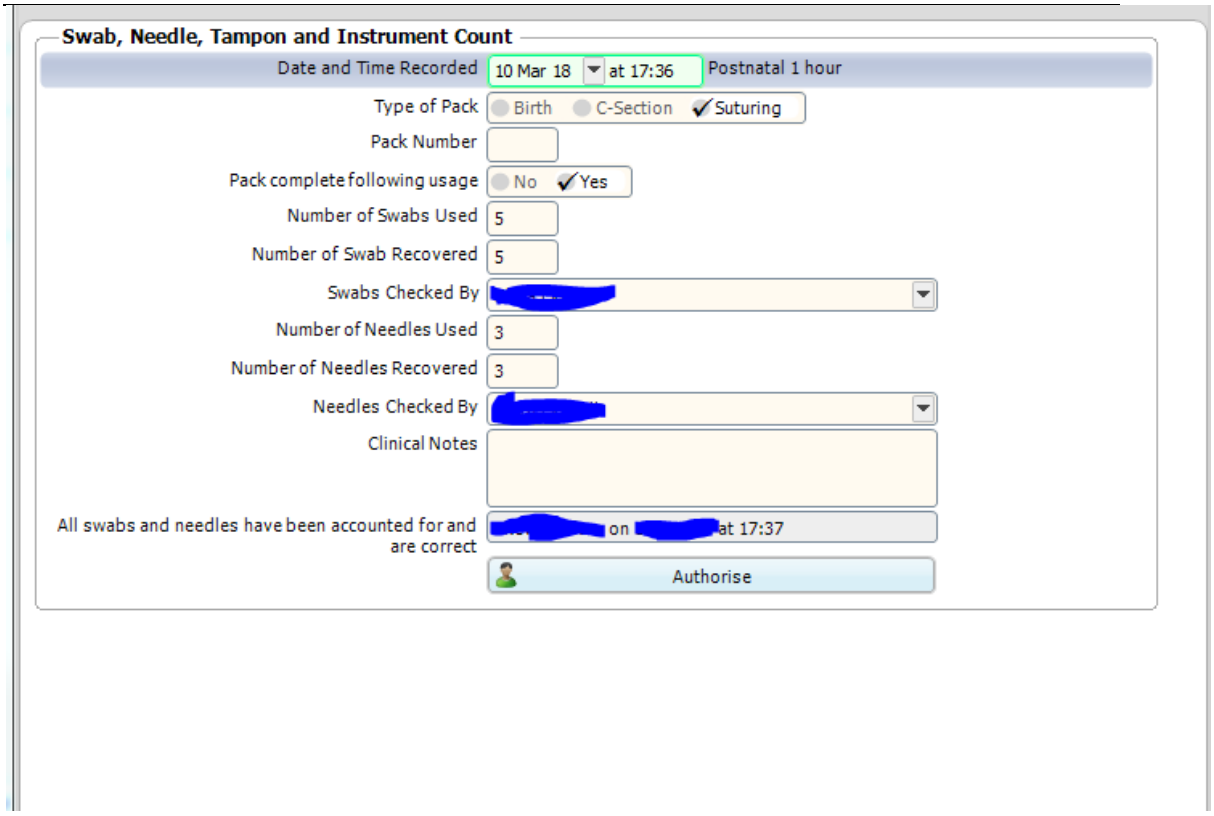
## Appendix One

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Date and Time Recorded
10 Mar 18
at 17:36
Postnatal 1 hour
Type of Pack
Birth
C-Section
Suturing
Pack Number
Pack complete following usage
No
Yes
Number of Swabs Used
5
Number of Swab Recovered
5
Swabs Checked By
Number of Needles Used
3
Number of Needles Recovered
3
Needles Checked By
Clinical Notes
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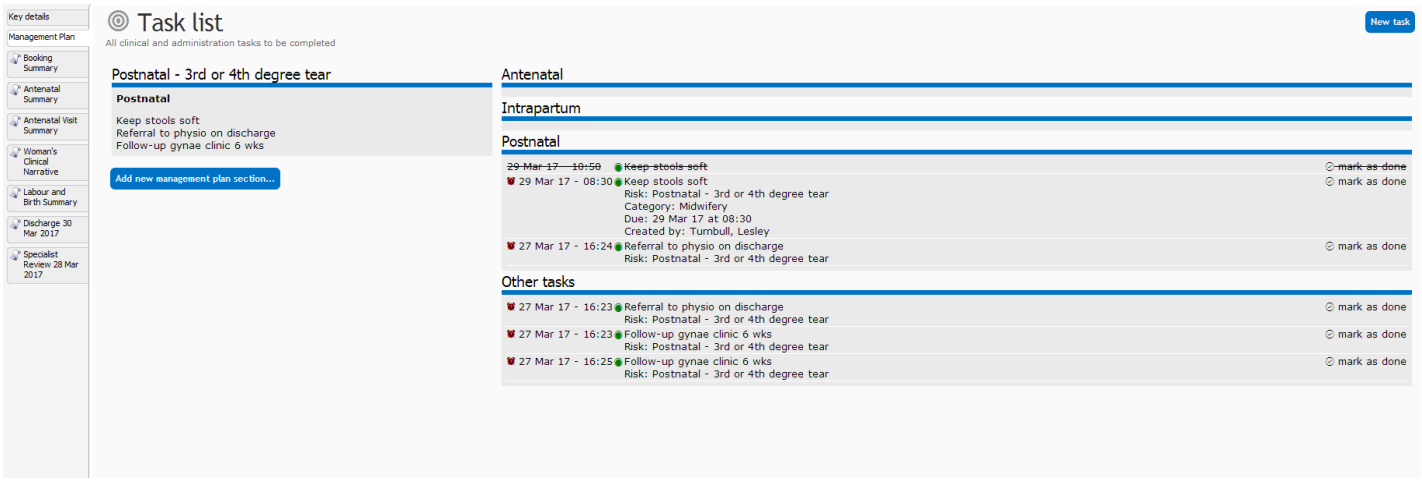
on
at 17:37
Authorise

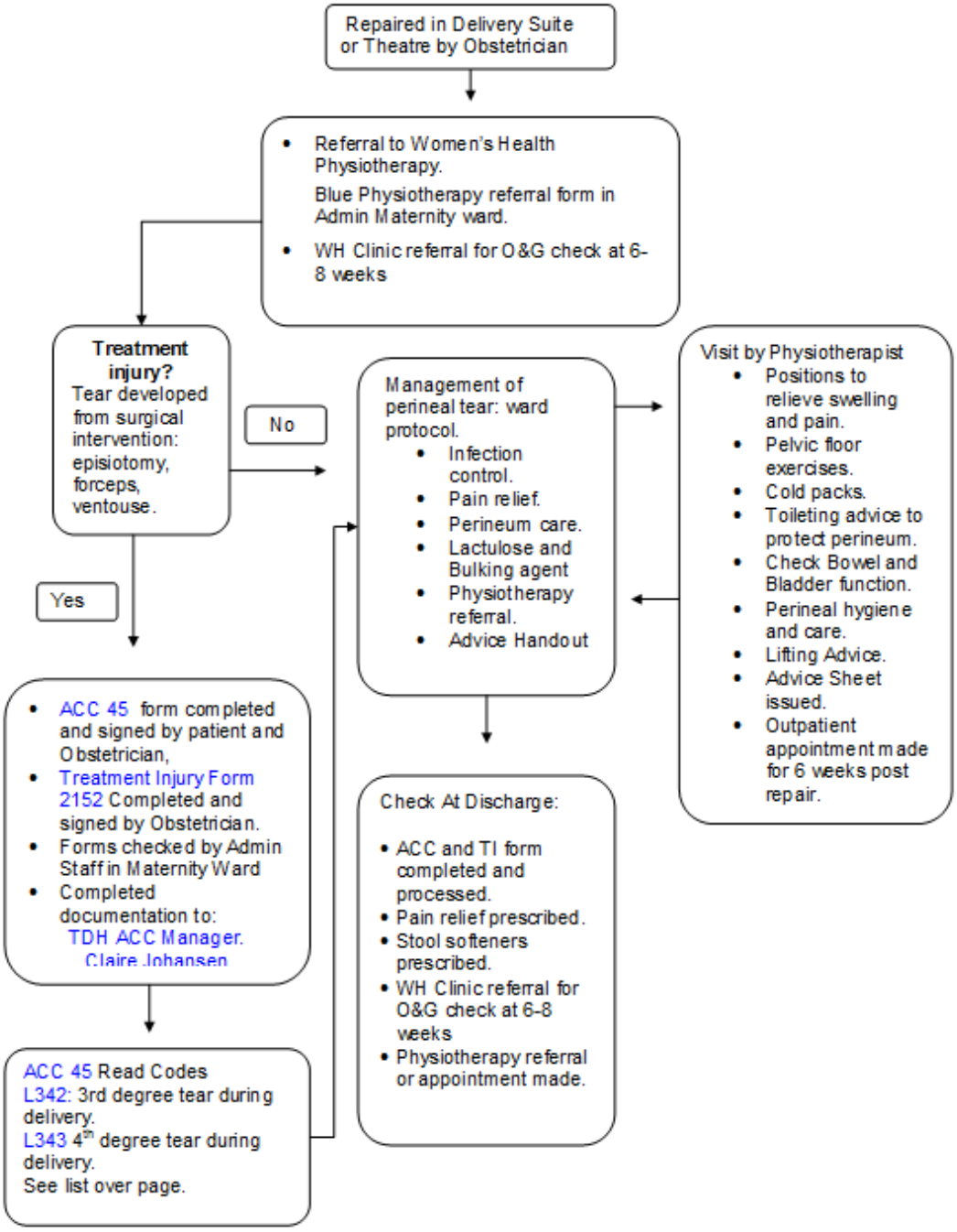

Key details
Management Plan
Booking Summary
Antenatal Summary
Antenatal Visit Summary
Woman's Clinical Narrative
Labour and Birth Summary
Discharge 30 Mar 2017
Specialist Review 28 Mar 2017
Task list
All clinical and administration tasks to be completed
New task
Postnatal - 3rd or 4th degree tear
Postnatal
Keep stools soft
Referral to physio on discharge
Follow-up gynae clinic 6 wks
Add new management plan section...
Antenatal
Intrapartum
Postnatal
29 Mar 17 - 10:50 Keep stools soft mark as done
29 Mar 17 - 08:30 Keep stools soft mark as done
Risk: Postnatal - 3rd or 4th degree tear
Category: Midwifery
Due: 29 Mar 17 at 08:30
Created by: Turnbull, Lesley
27 Mar 17 - 16:24 Referral to physio on discharge mark as done
Risk: Postnatal - 3rd or 4th degree tear
Other tasks
27 Mar 17 - 16:23 Referral to physio on discharge mark as done
Risk: Postnatal - 3rd or 4th degree tear
27 Mar 17 - 16:23 Follow-up gynae clinic 6 wks mark as done
Risk: Postnatal - 3rd or 4th degree tear
27 Mar 17 - 16:25 Follow-up gynae clinic 6 wks mark as done
Risk: Postnatal - 3rd or 4th degree tear

**Appendix two**

Patient Name: ..... Unit Number: .....

# Management of 3rd & 4th Degree Perineal Tear.

( Oasis: Obstetric Anal Sphincter Injuries )



Patient Name: ..... Unit Number: .....

# ACC 45 Read Codes

(Highlighted codes are suggested only, please use own clinical judgement.)

| | |
|---|---|
| L342. | Third degree perineal tear during delivery |
| L3420 | Third degree perineal tear during delivery, unspecified |
| L3421 | Third degree perineal tear during delivery - delivered |
| L3422 | Third degree perineal tear during delivery with p/n problem |
| L342z | Third degree perineal tear during delivery NOS |
| L343. | Fourth degree perineal tear during delivery |
| L3430 | Fourth degree perineal tear during delivery, unspecified |
| L3431 | Fourth degree perineal tear during delivery - delivered |
| L3432 | Fourth degree perineal tear during delivery with p/n problem |
| L343z | Fourth degree perineal tear during delivery NOS |

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