# Document Control

| Title | | | |
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| **Care and Repair of Perineal Trauma after Childbirth Guidelines Guideline** | | | |
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# CONTENTS

# 1 Purpose

1.2. The purpose of this document is to ensure adherence to evidence-based practice. This document has been prepared using evidence from the National Institute for Health and Clinical Excellence (NICE); the Royal College of Obstetricians & Gynaecologists (RCOG); the Royal College of Midwives (RCM) and the National Library for Health

1.3. The policy applies to all staff employed within Maternity Services.

1.4. Implementation of this policy will ensure that a consistent approach is taken to:

- Inspect the perineum, vagina, anus and rectum after childbirth.
- Effect perineal, vaginal, anal and rectal repair.
- Document the care and advice given.

# 2. Definitions

## Definition of Perineal Trauma

Perineal trauma is defined as injury to the labia, vagina, urethra, clitoris, perineal muscles or anal sphincter[1]

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| First degree | Injury to perineal skin only. |
| Second degree | Injury to perineum involving perineal muscles but not involving anal sphincter |
| Third degree | Injury to perineum involving the anal sphincter complex:<br><br>3a. Less than 50% of EAS* thickness torn<br><br>3b. More than 50% of EAS* thickness torn<br><br>3c. Both EAS* and IAS* torn |
| Fourth degree | Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium |

*Internal/External Anal Sphincter

## Definition of Episiotomy

An episiotomy is a surgical incision in the perineum to expedite vaginal delivery or to control perineal tearing.

# 3. The purpose of Care and Repair of the Perineal Trauma after Childbirth

Perineal trauma can have a significant adverse impact on a woman's short and long term health. Failure to correctly identify and repair perineal damage can lead to physical, psychological, sexual and social dysfunction.

Inadequate repair of the perineum may lead to increased bleeding; higher rates of infection; more pain; urinary and faecal incontinence.

Failure to identify perineal trauma or sub-optimal management may have a lasting effect on the woman and may expose the Trust to risk of litigation

## Predisposing factors

Clinicians should be vigilant to factors that lead to a greater risk of perineal trauma3

- Birthweight over 4kg
- Persistent occipito-posterior position
- Nulliparity
- Induction of labour
- Epidural analgesia
- Shoulder dystocia
- Midline episiotomy
- Instrumental delivery

## Assessment of Perineal Trauma

All women who have had a vaginal delivery should undergo perineal assessment with consent.

Before assessing the perineum for trauma, the healthcare professional will:

- Give a full explanation for the examination and its objectives
- Offer adequate analgesia
- Optimise maternal positioning and ensure good lighting

Perineal examination must be undertaken gently and in a sensitive manner, conducive to the woman's preferences. Practitioners must consider changing gloves prior to examination.

Assessment must be made in a systematic manner, visualising the external and internal structures. Practitioners must inspect the following, noting any trauma, its extent and the structures involved:

- Fourchette
- Labia majora
- Labia minora
- Clitoris
- Urethra
- Posterior vaginal wall
- Anterior vaginal wall
- Anus

If there is any suspicion that the perineal muscles are damaged, assessment of genital trauma should include a rectal (PR) examination to assess whether there has been any damage to the external or internal anal sphincter and look for button-hole tears in the vagina.

The timing of this systematic assessment should not interfere with mother–infant bonding unless the woman has bleeding that requires urgent attention.

The woman should usually be in lithotomy position to allow adequate visual assessment of the degree of the trauma and for the repair. This position should only be maintained for as long as is necessary for the systematic assessment and repair.

The woman should be referred to a more experienced healthcare professional if uncertainty exists as to the nature or extent of trauma sustained.

The systematic assessment and its results should be fully documented, possibly pictorially on page 18 of the Perinatal Institute 'Birth Notes'.

## Perineal Repair

Clinicians who undertake repair of the perineum must be able to demonstrate their competence. Repair of 3rd and 4th degree tears will be conducted by a senior doctor - SAS grade or above.

Consent for perineal repair must be obtained and documented on page 18 of the Perinatal Institute 'Birth Notes'.

Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.

Perineal repair should only be undertaken with tested effective analgesia in place using infiltration with up to 20 ml of 1% lidocaine or equivalent, or topping up the epidural (spinal anaesthesia may be desirable, irrespective of the operator). If the woman reports inadequate pain relief at any point this should immediately be addressed.

Women should be advised that in the case of first-degree trauma, the wound should be sutured in order to improve healing, unless the skin edges are well opposed.

Women should be advised that in the case of second-degree trauma, the muscle should be sutured in order to improve healing. If the skin is apposed following suturing of the muscle in second-degree trauma, there is no need to suture it.

Where the skin requires suturing a continuous subcuticular technique is recommended. Interrupted sutures may be more suitable where infection is suspected; where there is poor haemostasis; or where there is suspected difficulty in opposing tissue.

Perineal repair should be undertaken with an absorbable synthetic suture material (Vicryl Rapide 2/0) using a continuous non-locked suturing technique for the vaginal wall and muscle layer.

Rectal non-steroidal anti-inflammatory drugs should be offered routinely following perineal repair of first- and second-degree trauma provided these drugs are not contraindicated.

**The following must be observed when performing perineal repair**:

Perineal trauma should be repaired using an aseptic technique.

Equipment should be checked and swabs and needles counted before and after the procedure.

Good lighting is essential to see and identify the structures involved.

Difficult trauma should be repaired by an experienced practitioner in theatre under regional or general anaesthesia. An indwelling catheter should be considered for 24 hours to prevent urinary retention.

Good anatomical alignment of the wound should be achieved, and consideration given to the cosmetic results.

Rectal examination should be carried out after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa.

Following completion of the repair, an accurate detailed account should be documented on page 18 of the Perinatal Institute 'Birth Notes', covering the extent of the trauma, the method of repair and the materials used including a swab count, needle count and tampon count.

Information should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises. Some women may need further support and assurance following the repair from the appropriate health professional regarding extent of the trauma and recovery, these discussions and the giving of the information must be documented.

## Principles of Perineal Repair

Check the extent of the trauma by thoroughly examining the vagina and perineum to establish the extent of the trauma, this is achieved using x-ray detectable swabs. Cotton wool balls must not be used.

A rectal examination should be performed as part of the assessment.

Suture as soon as possible after delivery - it is less painful and reduces the risk of infection. Following a water birth it is advisable to delay suturing for 1 hour following the birth.

Good lighting is essential to carry out the repair to visualise and identify the structures involved.

Handle tissue gently using non-toothed forceps.

Ensure good anatomical restoration and alignment to facilitate healing.

Close all dead space – ensure haemostasis and prevent infection.

Use minimal amount of suture material, and do not over tighten suture or knots. This may impede healing.

Following the repair a rectal examination should be performed to ensure no suture material has been inserted through the rectal mucosa.

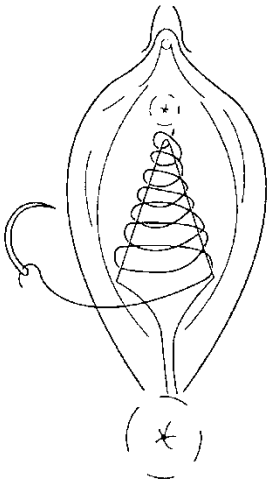
Advise women about perineal hygiene and pelvic floor exercises.

## Method of Perineal Repair

A loose, continuous non-locking suturing technique used to appose each layer, is associated with less short-term pain compared with the traditional interrupted method.

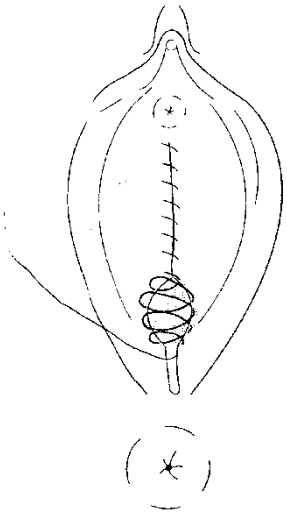
**Step 1 Suturing the vaginal wall**

Identify the apex.
Insert the anchoring suture 0.5 cm above the apex.
Repair the vaginal wall with a continuous non-locking stitch with approximately 0.5cm between each stitch.
Continue to suture until the hymenal remnants are reached, ensuring sutures are not placed in the hymenal remnants.
Place the needle behind the hymenal remnants and emerge in the centre of the perineal muscle.



**Step 2 Suturing the perineal muscle**

Check the depth of the trauma.
Repair the perineal muscles in one or two layers with the same continuous stitch.
Ensure the muscle edges are apposed carefully leaving no dead space.
Visualise the needle between sides to prevent stitches being inserted into the rectal mucousa.
On completion of the muscle layer, the skin edges should align so that they can be brought together without tension.



**Step 3 Suturing the skin**

Reposition the needle.
Commence sub-cuticular suturing of the skin from the end of the wound nearest to the anus.
Stitches are placed below the surface of the skin, the point of the needle should be repositioned between each side, so that it faces the skin edge being sutured.
Continue taking bites of tissue from each side until the superior wound edge is reached.

Hyperlink: Sub-cuticular repair

Sweep the needle behind the fourchette back into the vagina. Pick up a small amount of vaginal tissue to tie off the stitch and cut (the knot is formed inside the vagina to minimise discomfort).

Alternatively, the repair may be completed using the “Aberdeen” knot. The ‘Aberdeen knot’ is a method to secure that ensures that the knot is completely inverted in the mucosa with minimal knot bulk at the surface.

Link: Aberdeen knot

## Immediate Post-operative Care

Inspect the repair to check that haemostasis has been achieved. NB – an excessive amount of suture material may well cause severe discomfort in the puerperium and beyond.

Only carry out the required amount of suturing to achieve haemostasis. Remove the vaginal tampon, if used, and account for all instruments, swabs and needles – discard sharps safely. Record same in the Perinatal Institute notes.

Perform a rectal examination following completion of the repair to detect any suture material which may have been accidentally inserted through the rectal mucosa.

Diclofenac Sodium 100mg may be given PR, if no contraindications exist. Remove woman's legs from lithotomy position. Make the woman comfortable.

Document repair in the Maternity Record and document the administration of local anaesthetic and Diclofenac Sodium on the Drug Administration chart.

Any difficulty experienced in suturing should be documented in the labour notes, e.g. excessive bleeding, friable tissue, or haematoma.

Explain the extent of trauma and advise the woman with regard to hygiene and pain relief associated with perineal trauma.

### Additional notes

Where a woman is subsequently readmitted for secondary perineal repair and/or referred to a Gynaecologist with problems relating to all types of perineal repair a Datix incident report should be completed for review by the Maternity Risk Manager; processed and escalated in line with the risk management process and trigger the audit process.

Where there is a suspicion of Female Genital Mutilation (FGM) or trauma to the genitalia inconsistent with obstetric trauma, referral to a consultant obstetrician or gynaecologist should be made. FGM is a criminal offence in the UK. There is a mandatory duty to report FGM in children under the age of 18. Please seek the Advice of the Named Midwife for Safeguarding Children & Young People.

There is a mandatory requirement for health care professionals to submit their FGM data for both children and adults via the Health & Social Care Information Centre. Further details can be accessed on their website: http:// www.hscic.gov.uk/FGM.Submission became mandatory for acute trusts, GP practices and mental health trusts in 2015

## Management and Care of Third and Fourth Degree Tears

The overall risk of obstetric anal sphincter injury is 1% of all vaginal deliveries. With increased awareness and training, there appears to be an increase in detection of anal sphincter injury.

Obstetricians who are appropriately trained are more likely to provide a consistent, high standard of anal sphincter repair and contribute to reducing the extent of morbidity and litigation associated with anal sphincter injury. Repair of third and fourth degree tears will be conducted by SAS grade doctors or above.

Obstetric anal sphincter repair should be performed by appropriately trained practitioners.

Formal training in anal sphincter repair techniques is recommended as an essential component of obstetric training.

For repair of the external anal sphincter, either an overlapping or end-to-end (approximation) method can be used, with equivalent outcome. Where the IAS can be identified, it is advisable to repair separately with interrupted sutures.

Repair of third and fourth degree tears should be conducted in an operating theatre, under regional or general anaesthesia.

When repair of the EAS muscle is being performed, either monofilament sutures such as polydiaxanone (PDS) or modern braided sutures such as polyglactin (Vicryl®) can be used with equivalent outcome.

When repair of the IAS muscle is being performed, fine suture size such as 3-0 PDS and 2-0 Vicryl may cause less irritation and discomfort.

When obstetric anal sphincter repairs are being performed, burying of surgical knots beneath the superficial perineal muscles is recommended to prevent knot migration to the skin.

Women should be warned of the possibility of knot migration to the perineal surface, with long-acting and non-absorbable suture materials.

Obstetric anal sphincter repair should be performed by appropriately trained practitioners.

Formal training in anal sphincter repair techniques is recommended as an essential component of obstetric training.

The use of broad-spectrum antibiotics is recommended following obstetric anal sphincter repair to reduce the incidence of postoperative infections and wound dehiscence.

The use of postoperative laxatives is recommended to reduce the incidence of postoperative wound dehiscence.

All women should be offered physiotherapy and pelvic-floor exercises for 6–12 weeks after obstetric anal sphincter repair.

If a woman is experiencing incontinence or pain at follow-up, referral to a specialist gynaecologist or colorectal surgeon for endoanal ultrasonography and anorectal manometry should be considered.

A small number of women may require referral to a colorectal surgeon for consideration of secondary sphincter repair.

Women should be advised that the prognosis following EAS repair is good, with 60–80% asymptomatic at 12 months. Most women who remain symptomatic describe incontinence of flatus or faecal urgency.

All women who sustained an obstetric anal sphincter injury in a previous pregnancy should be counselled about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery.

All women who sustained an obstetric anal sphincter injury in a previous pregnancy should be advised that there is no evidence to support the role of prophylactic episiotomy in subsequent pregnancies.

All women who have sustained an obstetric anal sphincter injury in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should have the option of elective caesarean birth.

When third and fourth degree repairs are performed, it is essential to ensure that the anatomical structures involved, method of repair and suture materials used are clearly documented and that instruments, sharps and swabs are accounted for.

The woman should be fully informed about the nature of her injury and the benefits to her of follow-up. This should include written information where possible.

Women who have had obstetric anal sphincter repair should be offered a review between 6 & 12 weeks postpartum by a consultant obstetrician or gynaecologist or a designated professional with the necessary specialist skills. This appointment will be made via the consultant's secretary prior to discharge from hospital.

## 4. Education and Training

All relevant healthcare professionals will be able to demonstrate their competence in perineal /genital assessment and repair.

Perineal /genital assessment repair training sessions are offered in-house.

## 5. Consultation, Approval and Ratification Process

The author consulted with all relevant stakeholders. Final approval was given by the Maternity Specialty Governance Group.

All versions of these guidelines will be archived in electronic format by the author within the maternity team policy archive.

Any revisions to the final document will be recorded on the Document Control Report.

To obtain a copy of the archived guidelines, contact should be made with the maternity team.

## 6. Monitoring Compliance with and the Effectiveness of the Guideline

Monitoring of implementation, effectiveness and compliance with the Care and Repair of Perineal Trauma Guidelines is the responsibility of the senior clinical/management team.

## 7. References


- RCOG. Methods and materials used in perineal repair. London: RCOG; 2004. Green-top guideline No. 23.
- Sultan AH. Editorial: Obstetric perineal injury and anal incontinence. Clin Risk 1999;5:193–6.
- RCOG. The management of third and fourth degree perineal tears. London; RGOG; 2007. Green-top guideline No. 29
- Intrapartum care for healthy women and babies clinical guideline [CG190]Published date: December 2014 Last updated: February 2017; https://www.nice.org.uk/guidance/cg190/chapter/recommendations#care-of-the-woman-after-birth
- NHS Quality Improvement Scotland. Perineal repair after childbirth – A procedure and standards tool to support practice development. August 2008; http://www.nhshealthquality.org


## 8. Associated Documentation

https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/12/Female-Genital-Mutilation-FGM-Policy.pdf