1. Classification of Perineal Tears

<table>
<thead>
<tr>
<th>GRADE OF TEAR</th>
<th>FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>First degree</td>
<td>Laceration of the vaginal epithelium or perineal skin only</td>
</tr>
<tr>
<td>Second degree</td>
<td>Involvement of the perineal muscles but not the anal sphincter</td>
</tr>
<tr>
<td>Third degree</td>
<td>Disruption of the anal sphincter muscles</td>
</tr>
<tr>
<td></td>
<td>- Grade 3a &lt;50% thickness of external sphincter torn</td>
</tr>
<tr>
<td></td>
<td>- Grade 3b &gt;50% thickness of external sphincter torn</td>
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<tr>
<td></td>
<td>- Grade 3c Internal sphincter also torn</td>
</tr>
<tr>
<td>Fourth degree</td>
<td>Disruption of the anal sphincters and rectal epithelium</td>
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</tbody>
</table>

2. Risk factors
- Instrumental assistance
- Short stature, short perineum
- OP position
- First vaginal delivery, especially if aged over 30 years
- Prolonged active second stage (over 60 minutes)
- Epidural
- Previous large tear

3. Training
- All relevant healthcare professionals should attend training in perineal / genital assessment and repair, and ensure that they maintain these skills
- A registered midwife may repair first and second degree tears, episiotomies and uncomplicated labial tears
- Third and fourth degree repairs should be undertaken by someone skilled in the repair of third and fourth degree tears, i.e. obstetric registrar, obstetric consultant

4. Assessment
- Before assessing for genital / perineal trauma, healthcare professionals should:
  - Explain to the woman what they plan to do and why
  - Offer analgesia
  - Ensure good lighting
  - Position the woman so that she is comfortable and so that the genital structures can be seen clearly (usually in lithotomy)
- The initial examination should be performed gently and with sensitivity and may be done in the immediate period following birth
- Systematic assessment should be carried out following all vaginal deliveries.
- In the presence of trauma (tear / episiotomy) the assessment should include a rectal examination to exclude 3rd or 4th degree tear
Systematic assessment of genital trauma should include:
- Further explanation of what is planned and why
- Confirmation by the woman that analgesia is adequate
- Visual assessment of the trauma, the structures involved, the apex of the injury
- Assessment of bleeding
- A rectal examination if there is any suspicion of sphincter involvement

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

The woman should usually be in lithotomy (but not longer than necessary) to allow adequate visual assessment of the degree of the trauma and the repair.

After completion of the repair, the extent of the trauma, the method of repair and the materials used should be accurately documented with a drawing if needed.

5. Perineal repair

Perineal trauma should be repaired using aseptic techniques (sterile gown, gloves, drapes).

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

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

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

Perineal repair should only be undertaken after effective analgesia is ensured either by infiltration with up to 20 mL of 1% lignocaine or topping up the epidural.

If the woman reports inadequate pain relief at any point this should be addressed immediately. Ask for more experienced assistance if in doubt regarding the extent of trauma or structures involved.

1st degree tears do not need to be sutured if the skin is in alignment and there is no bleeding.

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

Perineal repair should be undertaken using a continuous non-locked suturing technique for the vaginal wall and muscle layer.

An absorbable synthetic suture material should be used to suture the perineum.

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

If the skin is neatly opposed after suturing the muscle in second-degree trauma, there is no need to suture it.

Where the skin does require suturing, this should be undertaken using a continuous subcuticular technique.

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

Information should be given to the woman about the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises.

Rectal non-steroidal anti-inflammatory drugs (e.g. diclofenac 100 mg or indomethacin 100mg) should be offered routinely following perineal repair of first and second-degree trauma provided these drugs are not contraindicated.

Contraindications include postpartum haemorrhage, preeclampsia, renal disease, concurrent use of other NSAIDs, aspirin, digoxin.

Follow up examination at 6 weeks or earlier.

Consent for any type of assessment and repair must be obtained and documented within the patient health records. If a woman chooses not to be sutured, evidence of information and advice given must be documented.
6. Episiotomy
This procedure should not be performed routinely but only where there are specific fetal or maternal indications.

Performing an episiotomy:
- If an effective epidural anaesthetic is in place it should be topped up for delivery with the patient upright to get best coverage of the perineal area. If there is not a good epidural, the perineum should be infiltrated with local anaesthetic.
- A medio-lateral episiotomy at 60° angle is recommended:

7. Repair of 2nd degree tear
The Consultant Obstetricians have advised that 2nd degree tears should be sutured.

A rectal examination should be performed to exclude a 3rd/4th degree tear. Episiotomy/tears extending to the anus or anal margin should be seen by a Specialist Registrar who will make the decision regarding suturing.

8. Repair of 3rd or 4th degree tear
8.1 Identification of injury
The understanding of normal anal sphincter anatomy, adequate assessment of the obstetric trauma and appropriate repair are essential to restoration of continence.

8.2 Prerequisites
- A repair should only be performed by a doctor who is experienced in anal sphincter repair (i.e. has attended a teaching session or course)
- For 4th degree tears a Consultant Obstetrician has to be informed and surgical opinion may be sought at the consultant's discretion.
- Any untrained obstetrician may carry out the repair but MUST be SUPERVISED by a Consultant Obstetrician or trained SpR.
- Repair should be conducted in an operating theatre where there is access to good lighting, appropriate equipment and aseptic conditions.
- General or epidural/spinal anaesthesia needs to be given prior to the commencement of the procedure.
- It is important that informed consent is obtained prior to the procedure. This should be recorded in the obstetric notes.

8.3 Procedure
- The full extent of the injury should be assessed in lithotomy position by vaginal and rectal examination.
- In the presence of a 4th degree tear the torn rectal mucosa should be repaired with Vicryl 2/0 interrupted, surgical knots pointing into the rectal lumen.
- The anal sphincters should be repaired with 2.0 PDS.
- The internal sphincter should be identified and sutured separately from the external sphincter.
- The ends of the torn muscles should be grasped and overlap repair should be performed with interrupted or mattress 2/0 PDS sutures. This may necessitate mobilisation of the external sphincter by sharp dissection. **Note there is a deep, superficial and subcutaneous part of the external anal sphincter.**
- Reconstruction of the torn perineal body is essential with 2/0 Vicryl (not ‘Rapide’) Sutures, to provide support to the sphincter repair.

Ensure adequate documentation by using page 17 and 18 in intrapartum care (yellow) notes. Complete risk management form.
8.4 Post-operative instructions

- Prevention of constipation
  To reduce the risk of passing a large bolus of hard stool, which may disrupt the repair, a stool softener must be prescribed (e.g. lactulose).

- Prevention of infection
  Intravenous antibiotics in theatre (augmentin 1.2g iv) and continued 625mg tds po for 1/52. Use alternative antibiotics plus metronidazole if allergic to penicillin.

- Pain control
  Regular oral analgesia, avoid opiates e.g. codeine or oramorph

- Bladder care
  Insert a Ch 14 Foley catheter with instagel and leave on free drainage for at least 24 hours.

8.5 Follow-up

- Appointment to be made for Perineal Follow up Clinic (first Thursday of the month) at 6-8 weeks. Clinic diary on CDS. Appointment to be made before woman transferred to the ward. Letter blanks available (within 3rd degree tear pack) to be filled in and given to the woman on discharge from postnatal ward.

- Anorectal studies
  A red top referral for anorectal studies (to be performed at 9 to 12 months post delivery) should be sent to Mr. Oppong’s secretary. NB the risk of faecal incontinence increases after the second vaginal delivery.

9. Swab counts

All swabs used in Maternity must be x-ray detectable, not less than 30 cm x 30 cm and have tails (this is the only type of swab available on labour ward). A swab count must be conducted prior to and following any procedure in which they are used, e.g. perineal repair. This must be clearly documented, together with the names and signatures of the persons conducting the swab count, within the birth record or surgical booklet, if procedure undertaken in theatre.

If the second person involved in the count is a maternity support worker, it is the midwife/obstetrician’s responsibility to sign off the completed swab count.

Any swabs deliberately left in the vagina MUST be clearly documented together with a management plan for their removal. The sticker shown in figure 1 MUST be used and placed in the patient record.

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**ATTENTION**

**PACKS REMAIN INSIDE**

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>TYPE</th>
<th>INITIAL-DATE</th>
</tr>
</thead>
</table>

*Figure 1* Sticker to be completed and placed in patient notes if swabs remain in situ on transfer between CDS and theatre*
10. Patient information
Patient information leaflet ‘Information and advice for women who have sustained a 3rd or 4th degree tear during childbirth’ should be given. This leaflet is available in the third degree tear pack and on the postnatal ward.
Where there are communication or language support needs assistance can be obtained via patient advice and liaison service (PALS) and interpretation services.
For all types of perineal trauma information should be given to the patient re: perineal care and personal hygiene. Perineal checks must be carried out by the midwife and any deviations from normality referred for medical advice.

11. Audit and monitoring
Annual audit of perineal trauma, including 3rd and 4th degree tears, presented to Clinical Effectiveness Committee and Clinical Governance and Risk Management committee. Findings, together with recommendations and action plan, published in Risk Management (RM) Newsletter for dissemination of information to all staff.

Follow-up of rate and cause of returns for women with problems relating to all types of perineal repair is achieved via Datix incident reporting system. Readmission of all women should be reported. This feeds into RM strategy for review.

12. Record keeping
It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the date and time together with signature and printed name.

Documentation with respect to perineal trauma:
Ensure adequate documentation by using either the perineal repair template in the Birth Notes page 18 or, if the repair is done in theatre, the documentation may be included within the surgical booklet. Documentation should include:
- The extent of trauma.
- Analgesia used for repair
- Material used
- Technique used
- Swab and needle count prior to and on completion of procedure
- Documentation of advice given

Postnatal documentation
A sticker for 3rd and 4th degree tear (see appendix 2) can be used and should be placed in the mother’s management plan. Alternatively, a hand written management may be documented.
Appendix 1. Care pathway for third and fourth degree perineal tear rehabilitation

Identify third and fourth degree tears

Repair third and fourth degree tears

Post-operative antibiotics, aperients, analgesia, and bladder care

Appointment for Perineal Follow-up clinic made via CDS diary

Reviewed at six weeks at Perineal follow-up clinic by midwife and physiotherapist for pelvic floor exercises and advice

Red top referral to Mr Oppong for anal physiology studies at 6-9 months

Appendix 2. Management of 3rd and 4th degree tears – sticker to be placed in notes

- Prevention of constipation - prescribe stool softener
- Prevention of infection - IV antibiotics in theatre and continued orally for 1/52.
- Regular analgesia
- Bladder care - catheter in situ for at least 24 hours.
- Appointment for 6-8 weeks at Perineal Follow up clinic (diary on CDS) Anorectal studies - red top referral for anorectal studies (to be performed at 6-9 months post delivery)
- Patient information leaflets given re: pelvic floor exercises and care of stitches prior to discharge home.
### Monitoring Audit:

**Auditable standards:**
- Management of 3 / 4 degree tears
- Standards of record keeping in relation to all perineal trauma
- Documented patient information and PIL
- Audit of documentation and implementation of swab counts
- In addition - please see perineal audit proforma

Please refer to audit tool, location: ‘Maternity on cl2-file11’, Guidelines

**Reports to:**
- Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit
- Service Line Business Meeting

**Frequency of audit:**
- Annual

**Responsible person:**
- CDS Manager

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### Training requirements

Audit of training needs compliance – please refer to TNA policy

**Training needs analysis:**
Please refer to ‘Training Needs Analysis’ guideline together with training attendance database for all staff

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### Cross references

- Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
- Antenatal Guideline 44 – Guideline Development within the maternity Services

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### References


Royal College of Obstetricians and Gynaecologists (RCOG) 2004. **Methods and materials used in perineal repair.** RCOG, London (UK):

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### Version

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### Changes

- Swab count sticker if transferred between CDS and theatre with swabs in situ.
- Update Dec 12 – 3rd/4th degree repair sticker added (no version change)
- Patients to be referred to a 6 week Perineal Follow-up clinic

### Date Ratified

December 2014

### Valid Until Date

December 2017
Perineal trauma including 3rd and 4th degree tear