Perineal Trauma: Prevention and Repair

Classification :	Guideline
Authors Name:	Georgena Leroux, Kate Omonua, Natalie Lucas, Erum Khan, Joseph Nattey
Authors Job Title:	Fetal surveillance Midwife, Obstetric Registrar, Practice Development Midwife, Consultant obstetrician, Consultant Obstetrician.
Authors Division:	Women and Children's
Departments/Group this Document applies to:	Maternity

Approval Group: • Women's health digital guideline review group • Women's health CIG	**Date of Approval:**	26/01/2022
	Last Review:	26/01/2022
	Review Date:	26/02/2025

Unique Identifier: MIDW/GL/124	**Status:** Approved	**Version No:** 5

Guideline to be followed by (target staff): Midwives, Student Midwives and Obstetricians, Physiotherapists

To be read in conjunction with the following documents:

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 15 – Premises and equipment
Regulation 17 – Good governance

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

Care of women in the antenatal period should include advice on how to reduce the risk of perineal trauma. Care of women immediately after birth includes assessment of the genital tract and perineum in order to establish if trauma was sustained during childbirth.

It is crucially important that appropriate assessment and treatment of any complications is undertaken as failure to do so can have long term consequences for the women's physical, emotional and psychological wellbeing. (NICE 2017).

Executive Summary

The purpose of this guideline is to ensure there is a consistent, evidence-based approach to the prevention, assessment and repair of all genital tract/perineal trauma.

Definitions

Abbreviations

- IV – Intravenous
- TDS – 3 times daily
- TTOs – Take home medicines
- GP – General Practitioner
- RCOG – Royal College of Obstetricians and Gynaecologists
- NICE – National Institute of Clinical Excellence
- OASI – Obstetric Anal Sphincter Injury
- EAS – External anal sphincter
- IAS – Internal anal sphincter
- PEARLS – PErineal Assessment Repair Longitudinal Study
- LocSSIP – Local Safety Standards for Invasive Procedures
- WHO – World Health Organisation
- ADAU – Antenatal Day Assessment Unit
- RCM – Royal College of Midwives
- OSATS – Objective Structured Assessment of Technical Skills

1.0 Roles and Responsibilities:

All members of staff undertaking perineal suturing should ensure that suturing is commenced within one hour of the delivery of the placenta and membranes. If this time is breached, an incident report must be completed.

If repair is declined it is essential to ensure that the woman fully understands the implications and that this is documented.

All clinicians must ensure competence and confidence with regards to the assessment, identification, and repair of genital tract/perineal trauma (within professional scope).

- Midwives (and student midwives with direct supervision from a midwife)
    - Provide women with information regarding prevention of perineal trauma (particularly OASI version 2 care bundle) in the antenatal period and document eCare.
    - Assess and diagnose degree of genital tract/perineal trauma, perform repair where appropriate and escalate to obstetrician as required
    - Give ongoing advice for postnatal care, refer to physiotherapy as appropriate, and arrange for obstetric follow up if indicated
    - Fully document advice given, consent, procedure and follow up plans.

- Maternity care assistants
    - Assist Midwives and Obstetricians with preparation for perineal repair including positioning, equipment, comfort of woman and family

- Obstetricians and Gynaecologists
    - Provide women with information regarding prevention of perineal trauma (particularly OASI version 2 care bundle)
    - Assess and diagnose degree of genital tract/perineal trauma, perform repair where appropriate and refer to Consultant as appropriate
    - Give ongoing advice for postnatal care, refer to physiotherapy as appropriate, and arrange for obstetric follow up if indicated
    - Fully document advice given, consent, procedure and follow up plans.

2.0 Implementation and dissemination of document

- This guideline will be available on the Trust intranet.
- The maternity practice development team will refer to this guideline when supporting staff members in achieving suturing competency and on all perineal suturing learning events.
- Staff are notified of a new or updated guideline via Microsoft Teams (Digital Guideline Review group Team)

3.0 Processes and procedures

3.1 Risk Assessment for perineal trauma

9 in every 10 first time mothers who have a vaginal birth will likely sustain a perineal tear, graze or episiotomy. Third degree tears occur in approximately 6% of vaginal births to first time mothers and less than 2% for women who have had a vaginal birth previously. Often, there is no clear cause for a 3rd or 4th degree tear, however they are more likely if;

- First vaginal birth
- Baby weight >4kg
- Prolonged second stage of labour
- Shoulder dystocia
- Instrumental birth
- Previous 3rd or 4th degree tear
- Women who are of South Asian origin (RCOG 2019)

3.2 Antenatal actions to reduce risk of perineal trauma

During the antenatal period, midwives and obstetricians should be discussing with women, the methods in which they can try to reduce their risk of tearing.

3.3.1 Perineal massage

Perineal massage from 35 weeks gestation is thought to enable the perineal tissues to expand more easily during birth for women who have not had a vaginal birth previously. Women who have practiced perineal massage are less likely to require an episiotomy during birth.

See appendix 1 for the advice to give women wishing to undertake perineal massage antenatally.

3.3.2 OASI2 Care bundle

The OASI Care bundle launched in 2016 successfully reduced rates of Obstetric Anal Sphincter Injury (OASI) using an evidenced based care bundle. The OASI2 care bundle has re-launched in 2021. The bundle covers 4 essential elements and consent must be gained for each element. See appendix 2 for infographic.

1. The midwife or obstetrician will discuss OASI and the OASI care bundle with the woman and explain what can be done to reduce the risk of OASI
2. The midwife or doctors conducting the birth will use manual perineal protection whilst communicating with the woman during birth to encourage a slow and guided birth. Manual perineal protection should be used for both spontaneous and assisted vaginal births
3. If clinically indicated, an episiotomy at 60 degrees from the midline should be performed at crowning
4. Following a vaginal birth, a thorough vaginal and rectal examination should be performed, even if the perineum appears intact to identify any tears

3.3 Assessing perineal trauma

- There must be a verbal discussion with the woman which includes benefits of assessing perineal trauma through a vaginal and rectal examination. These discussion's and whether consent was given must be documented in the woman's health record on eCare. If the woman declines assessment, the risks of this should be clearly documented. Translation (either face to face or via telephone service) should be used if the woman does not speak or understand english.

- Gently perform a full digital examination of the genital tract immediately post-delivery

- This should include both vaginal and rectal examination

- If there is any doubt or uncertainty regarding classification of perineal trauma, escalate to the Labour ward co-ordinator or obstetric registrar

- Document findings in the woman's birth record on eCare.

- When the perineum is intact, it is essential to examine the full genital tract for less obvious tears. Rectal examination is paramount to ensure that the anal sphincter remains intact.

3.3.2 Perineal trauma definitions

1st degree

- Injury to the skin only (of the fourchette and superficial perineal skin or vaginal mucosa)

2nd degree/ Episiotomy

- Involvement of the perineal muscles and fascia but not the anal sphincter

3.3.3 Labial tears/ grazes

- May or may not require repair, this will be dependent on location, depth and bleeding

3.3.4 3rd, 4th, clitoral and urethral tear

Involvement of the anal sphincter complex. There are 3 subcategories of 3rd degree tear, dependent on the involvement the external anal sphincter (EAS) and internal anal sphincter (IAS).

- **3a** – Less than 50% of EAS thickness torn
- **3b** – More than 50% of EAS thickness torn
- **3c** – IAS torn

- **4th degree** – A third degree tear with disruption of the anal epithelium

If a 3rd or 4th degree tear is suspected by a Midwife, examination by a registrar/consultant obstetrician is required. The gold standard for commencing repair should be an hour following delivery of the placenta. If this is not achieved, an incident report should be completed, and repair should be undertaken as soon as clinically possible. Repair must be undertaken in theatre.

- **Clitoral** – Tearing to the skin of or surrounding the clitoris
- **Urethral** – Tearing to the skin of or surrounding the urethra

If urethral or clitoral tear is suspected by a Midwife, examination by a registrar/consultant obstetrician is required. Dependent on clinical assessment, these tears may not require repair, this will be dependent on location, depth and bleeding

3.4 Repair of perineal trauma

There must be a verbal discussion with the woman which includes the benefits of perineal repair and risks or not repairing. In the event of a woman declining perineal repair, it should be ensured that the woman understands that all tears, including episiotomy other than non-bleeding, superficial 1st degree tears should be repaired to facilitate healing and correct alignment of perineal tissues. These discussion's and whether consent was given must be documented in the woman's health record on eCare.

3.4.2 Suture material

- 1st, 2nd degree tears and episiotomies should be sutured with Vicryl rapide 2.0
- Labial tears/ grazes should be sutured with Vicryl rapide 3.0

- 3rd and 4th degree tears should be sutured with
  - Rectal / Anal mucosa – 3.0 Vicryl
  - Internal anal sphincter – 3.0 PDS
  - External anal sphincter – 3.0 PDS
  - Perineal body muscles – 2.0 Vicryl Rapide
  - Skin – 2.0 Vicryl Rapide

- Clitoral/ urethral tears should be sutured with Vicryl Rapide 3.0 or Vicryl Rapide 4.0

3.4.2.1 Repair procedures

- See appendix 3 for repair of 1st/ 2nd degree tears and episiotomy

Repair should be undertaken according to the PEARLS technique as per the RCM/RCOG e-learning packages.

- See appendix 4 for repair of labial tears
- See appendix 5 for repair of 3rd/ 4th degree tears
- See appendix 6 for repair of clitoral/ urethral tears

3.5 Swab and instrument counts

- Swab and instrument counts must be conducted prior and following completion of perineal repair

- When perineal repair is undertaken in theatre, the swab and instrument count is undertaken by the theatre team with the suturing clinician.

- When perineal repair is undertaken on labour ward, these counts should be conducted by two clinicians (including maternity care assistants if appropriately trained)

- Use the white board in the birthing room to record the pre and post procedure counts.

- Pre and post procedure counts must be documented in the woman's birth record on eCare

- The swab and instrument counts must also be documented on the LocSSIPs form (see appendix 7) and in the tracer book kept in the labour ward sluice.

Please note, if the clinician conducting the repair changes mid procedure, an additional swab count must be conducted with the original clinician and the clinician taking over the procedure.

If a woman is transferred to theatre mid procedure – a swab count must be performed before leaving the room, if it necessary to leave a swab in situ, this must be clearly documented in the woman's birth record on eCare and verbalised in the WHO meeting.

3.6 Post birth advice and care

All women who sustain perineal trauma should be given the 'Looking after your pelvic floor when you have had a baby' leaflet (appendix 8). They should also be given the leaflet appropriate for their type of tear;

- Care of your perineum after the birth of your baby (appendix 9)
- RCOG Care of 3rd and 4th degree tear (appendix 10)
- Getting back into shape after your delivery (appendix 11)

The information in the leaflets given should also be verbalised when the leaflet is given and on discharge.

Physiotherapy will endeavor to see all women on the postnatal ward (Monday-Friday) who have perineal trauma. Women who have sustained a 3rd/4th degree tear and have not been seen whilst an inpatient will be sent an appointment for the co-located physio clinic.

Women should be offered a tube of medihoney post perineal repair to support with healing and comfort. The woman should be advised to apply a small amount to their suture line with a clean finger. Woman who are vegan or allergic to any ingredients in medihoney can be offered flaminal forte as an alternative.

3.7 Post – operative management of a 3rd/ 4th degree tear

Analgesia:

- Diclofenac 100mg (PR) is recommended analgesia; if this is contraindicated Paracetamol 1g (PR) can be used.
- Further regular analgesia must be prescribed prior to leaving theatre to ensure adequate pain relief in the postnatal period.
- Icepacks – the use of icepacks should be encouraged as per the NICE guidance for perineal pain. Physiotherapy advice states to use ice/gel pack wrapped in a damp cloth. The pack should be rested on the perineal area whilst lying on side to reduce pressure. It should be used for 5 minutes on then 5 minutes off then replaced for a further 5 minutes. This can be repeated hourly.

Bladder care:

- Following removal of catheter, voiding must be ensured within six hours. If the woman is unable to void, a bladder scan must be undertaken and the woman re-catheterised if the residual volume is greater than 200mls. Further advice should be sought from senior medical team.

Prophylactic antibiotics

- Intravenous antibiotics must be given in theatre and oral antibiotics should be continued for 7 days. The following regime should be used (unless contraindicate
- IV Cefuroxime 1.5g & IV Metronidazole 500mg in theatre
- Oral Cefalexin 500mg TDS & Metronidazole 400mg TDS for 7 days

Prevention of constipation

- Straining to pass hard stool may disrupt the anal sphincter repair. Simple measures including dietary advice and explaining the importance of avoiding constipation should be used in addition to drug treatment
- Women should be advised to seek medical attention early if they do become constipated
- All women must be prescribed a regular laxatives for a minimum of 10 days post repair
    - Prescribe Lactulose 15ml twice daily
    - DO NOT PRESCRIBE BULK FORMING AGENTS (Fybogel) as this has been shown to increase incontinence rates

Discharge management

- It is desirable for women to have a normal bowel action before discharge from hospital. If this is not possible, clinical assessment of women should be individualised and based on clinical need.
- Ensure the TTOs have been dispensed, explained and given to the woman.
- Ensure GP is informed of the perineal trauma (degree of tear) in discharge letter on eCare
- Advise woman to report any concerns, excess swelling, pain or signs of infection to a healthcare professional. Development of symptoms can occur months or years after birth. All women will be advised to see their General Practitioner at 12 months for review of symptoms. Women should be advised to seek medical attention early at any time they develop symptoms or complications
- Community midwife to assess the perineum and discuss any issues. Perineum must be observed at each postnatal visit, if the woman declines for the perineum to be viewed as part of the assessment the midwife must document in the woman's birth record and the reason why.

3.8 Management of subsequent pregnancies following a 3rd/ 4th degree tear

- All women who have had previous 3rd/4th tears should be referred to the Birth Choices clinic and to a consultant at booking

- If asymptomatic, women should be informed that there is no clear evidence as to the best mode of delivery following previous 3rd/4th degree tear. RCOG guidance indicates a risk of 5-7% recurrence following a 3rd/4th degree tear. Women should be counselled regarding the risk of developing anal incontinence or worsening symptoms with subsequent vaginal birth. All women who have suffered an OASI should therefore be counselled regarding the mode of delivery, and this should be clearly documented in the woman's pregnancy record on eCare

- If the woman is symptomatic or has abnormal anal endosonography or manometry, the option of caesarean section should be discussed. It could be argued that in these

women damage has already occurred, and risk of further damage may be minimal in terms of future management of their symptoms. However more recent research suggests that elective caesarean section is often suggested for women with EAUS/ manometry defects or if they are symptomatic.

- There is no clear evidence to support the role of routine prophylactic episiotomy. therefore, episiotomy should ONLY be performed if clinically indicated.

3.9 Co-Located perineal clinic

Women who have sustained a 3rd or 4th degree tear or otherwise complex tear will be referred to the co-located perineal clinic (physiotherapy and uro-gynae lead consultant) for 6-12weeks postnatal follow up. This referral is automated by the physiotherapy team.

Women will be called at 6 months postnatal by the physiotherapy team to ensure any symptoms remain resolved. If symptoms have deteriorated from the initial review at 6-12 weeks, the woman will be offered review in the co-located perineal clinic for consideration of EAUS and further physiotherapy support.

See appendix 12 for pathway.

3.10 Perineal wound breakdown

If women experience perineal breakdown, they should be referred to ADAU within 24 hours for obstetric review for an ongoing management plan including the consideration for suitability for perineal revision and re-suturing. This review should be undertaken by a registrar grade doctor or higher.

If the wound is not fully healed or the woman continues to be experience issues with the healing of her perineum at 4 weeks postnatal, she should be referred to the co-located perineal clinic using the co-located clinic referral form (appendix 13).

For less severe perineal breakdowns/ healing problems, midwives should carry out basic wound care using medihoney wound care gel application to the wound. Alternatively, flaminal hydro can be used for wounds that have minimal- moderate amounts of exudate whilst flaminal forte can be used for wounds that have moderate- high amounts of exudate. Tissue viability (bleep 1619, ext 85884) can be contacted for advice on wound healing/ broken down wounds.

3.11 Risk management

An incident form must be completed for all:

- 3rd/4th degree
- delays in perineal repair >1hour
- perineal breakdowns

3.12 Education and training

Midwives

- Annual completion of RCM PEARLS on-line training annually or access the maternity practice development team for a 1:1 training session
- Newly qualified Midwives (or Midwives joining the Trust without evidence of perineal repair competency) must complete the perineal repair proficiency document and be signed off prior to performing these procedures (See appendix 14)

Obstetricians

- All Obstetricians performing perineal repair are required to evidence of completion of competency (trainees must submit 3 OSATs confirming competence at Specialist Trainee grade 2 level as per the RCOG training matrix)

4.0 Statement of evidence/references

Statement of evidence:

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
5	11/2021	N Lucas, G Leroux, C Edley, J Nattey	Full review of document
4.2	09/2021	G Leroux, K Omonua	Changes to suggested suture material, post-operative management and care, documentation
4.1	04/2021		

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Rachel Bickley	Maternity Voices partnership		30/12/2021	Re wording to some sentences Linking statements to references	Partially
C Edley	Women's health physio	10/11/2021	10/11/2021	Co-located clinic update Perineal repair care	Yes
J Nattey	O&G Consultant – urogynae lead	10/11/2021	10/11/2021	Co-located update Perineal repair care	Yes
E Pearce	Tissue viability	16/09/21	21/09/21	Use of flaminal forte in place of medihoney for women with allergies to medihoney or	Yes

				women who are vegan	
Maternity guideline Meeting	Maternity	26/01/2022			Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
The number of third- and fourth-degree tears, as a percentage of vaginal deliveries	Continuous audit	OASI care bundle leads	Quarterly	Women's health audit and guideline meeting

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's and Children's	Department	Maternity
Person completing the EqIA	Natalie Lucas	Contact No.	
Others involved:	Georgena Leroux	Date of assessment:	01/11/2021
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*Midwives, student midwives, MCA's, Obstetricians, physiotherapy*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?			
Circulation via MS Teams			
How are the changes/amendments to the policies/services communicated?			
Circulation via MS Teams. Via the audit and guidelines midwife. During maternity teaching.			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
N/A			
Review date of EqIA	2025		

6.0 Appendices

Appendix1: Perineal massage RCOG leaflet

Perineal tears during childbirth

What you need to know during pregnancy

Royal College of Obstetricians & Gynaecologists

Your perineum is the area between your vagina and your back passage (anus). It can tear when you are giving birth, or sometimes your healthcare professional might recommend a cut to your perineum (episiotomy) to make more room for your baby to be born.

9/10 First-time mothers have a tear, graze or episiotomy

After the birth of your baby a healthcare professional will offer you an examination to see if you have a tear. They will advise you if you need stitches. Most tears heal within 6 weeks with no long-term problems. For women who do have problems after a tear (such as pain, difficulty going to the toilet, incontinence or mental health problems) specialist help is available.

Approximately 6 out of 100 women giving birth for the first time and 2 out of 100 women who have given birth vaginally before will have a deeper tear involving the back passage/anal sphincter muscle (a 'third- or fourth-degree tear'). These deeper tears will need repair in an operating theatre. You will be supported by healthcare professionals including physiotherapists after your recovery from a third- or fourth-degree tear.

Perineal massage and 'hands-on' birth

A kneeling or all-fours birthing position may be beneficial and reduce the severity of tearing.

You can ask your healthcare professional to support your perineum as your baby is being born, which reduces the risk of a third- or fourth-degree tear. This is called 'hands-on' birth.

From 35 weeks onwards, you may choose to try perineal massage until your baby is born, which has been shown to reduce the risk of tears. This is particularly beneficial for first-time mothers. You may wish to ask your partner to help with this.

Top tips

1. Use lubricant like vitamin E oil, almond oil or olive oil.
2. Hold one or both of your thumbs in the position shown for about one minute. You will begin to feel a stretching sensation. Keep breathing.
3. Gently massage the lower half of your vagina using a U-shaped movement for 2-3 minutes. Do this 2-3 times.
4. Repeat the massage daily, or when possible.

For more information about the types of tears that can happen in childbirth, and what can be done to help your recovery if you do tear, visit **www.rcog.org.uk/tears**

Published in October 2019

Appendix 2: OASI Care bundle 2

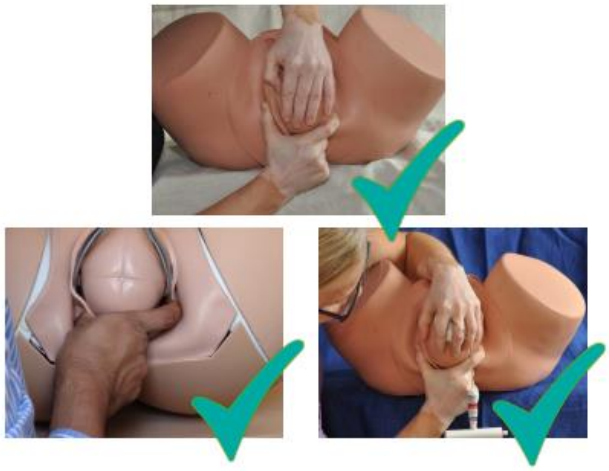
OASI
CARE BUNDLE

1. The **woman is aware** of the care bundle
2. **Episiotomy**, when indicated, at 60 degrees at crowning
3. Use of **manual perineal protection** whenever possible
4. **Perineal examination,** including a per rectum examination, carried out following all vaginal births

This material was developed by the OASI Care Bundle Project Team for use in the original 16 participating sites where the care bundle was implemented January 2017 – April 2018. They are now being made more widely available in response to wide ranging requests. The OASI Care Bundle is funded by the Health Foundation.

OASI
CARE BUNDLE

What technique are you using to support the perineum?



THE ROYAL COLLEGE OF MIDWIVES
The Health Foundation
This project is supported by the Health Foundation
Royal College of Obstetricians & Gynaecologists

This material was developed by the OASI Care Bundle Project Team for use in the original 16 participating sites where the care bundle was implemented January 2017 – April 2018. They are now being made more widely available in response to wide ranging requests. The OASI Care Bundle is funded by the Health Foundation.

Appendix 3: Repair of 1st and 2nd degree tear and episiotomy

Gain consent for perineal repair

↓

Position the woman into lithotomy (if required). Note the time of this position change in the woman's birth record on eCare.

↓

Adequate analgesia is essential, if the woman reports excessive pain during procedure the practitioner must re-evaluate the analgesia used

- Local infiltration: 10-20mls of Lignocaine 1% is recommended.
- If an existing epidural is still effective local infiltration may not be required

↓

Identify the apex

↓

Use a Surgeons square knot as the first securing knot above the apex of the tear

↓

Continuous non-locking suture to the vaginal epithelium up to the hymenal remnants, **do not suture up to the introitus.** Your needle and suture material should be passed under the hymnal remnants and then a further suture in front of the hymenal remnants must be secured. The suture material is then taken through to the trough of the muscle layer

↓

Continuous suture for muscle layer

↓

Use subcuticular suture to repair to the skin and close the fourchette. An Aberdeen knot must be used as the final securing knot. This knot should be place behind the fourchette.

↓

Complete a rectal examination with consent to ensure that the anal sphincter is fully intact, apply gentle upward pressure whilst the thumb should deliver gentle downward pressure at posterior introitus. Use a gentle rolling action to check the anal sphincter (approximately 10-2 o'clock).

Insert one index finger into the rectum and the other index finger into the vagina, applying gentle upward and downward pressure to check for any hidden tears.

↓

Ensure haemostasis

↓

Post repair pain relief

- Diclofenac 100mg (PR) is recommended analgesia
- Paracetamol 1g (PR) if diclofenac is contraindicated

↓

Note the time of the procedure completion in the woman's birth record on eCare.

Appendix 4: Repair of labial tear

Gain consent for perineal repair

↓

Position the woman into lithotomy (if required). Note the time of this position change in the woman's birth record on eCare.

↓

Adequate analgesia is essential, if the woman reports excessive pain during procedure the practitioner must re-evaluate the analgesia used

- Local infiltration: 10-20mls of Lignocaine 1% is recommended.
- If an existing epidural is still effective local infiltration may not be required

↓

Use a Surgeons square knot to secure individual sutures on both sides of the labial tear. If there are bilateral labial tears, both labial tears must be sutured to avoid fusion of the labia

↓

Ensure haemostasis

↓

Post repair pain relief

- Diclofenac 100mg (PR) is recommended analgesia
- Paracetamol 1g (PR) if diclofenac is contraindicated

↓

Note the time of the procedure completion in the woman's birth record on eCare.

Appendix 5: Repair of 3rd/ 4th degree tear

Gain consent for perineal repair. Repair should be undertaken in theatre with adequate lighting and pain relief (spinal anaesthetic) for the woman.

Position the woman into lithotomy (if used). Note the time of this position change in the woman's birth record on eCare.

Anal epithelium / rectal mucosa repair

Repair anal epithelium using interrupted sutures with the knots tied on the inside of the anal lumen

Internal anal sphincter repair

Internal anal sphincter injury should be identified and repaired separately from the external anal sphincter. Repair using end-to-end approximation with interrupted or mattress sutures.

External anal sphincter repair

If the tear involves <50% of the external anal sphincter (grade 3a) the sphincter should be repaired using an end-to-end repair method.

If the tear involves >50% of the external sphincter (grade 3b or above) then either an end-to-end or overlap technique can be used for repair. There is currently no reliable evidence to show that the overlap method is superior to the end-to-end (approximation) method. Operators should use the technique they are familiar with.

Complete the perineal repair

The vaginal mucosa should be sutured using a continuous non-locking suture, followed by repair of the perineal muscles. Care should be exercised when reconstructing the perineal muscles in order to provide perineal support to the sphincter repair. The skin should be repaired with a subcuticular suture.

Rectovaginal examination

A careful examination must be performed at the end of the repair to confirm complete repair and to ensure the swab and instrument counts are correct.

Note the time of the procedure completion in the woman's birth record on eCare.

Appendix 6: Repair of clitoral/ urethral tear

Gain consent for repair

Difficult tears should be repaired by an experienced obstetrician in theatre under regional anaesthesia – insert an indwelling catheter for 24 hours to prevent urinary retention and consider antibiotic prophylaxis.

Position into lithotomy (if required). Note the time of this position change in the woman's birth record on eCare.

Adequate analgesia is essential, if the woman reports excessive pain during procedure the practitioner must re-evaluate the analgesia used

- Local infiltration: 10-20mls of Lignocaine 1% is recommended.
- If an existing epidural is still effective local infiltration may not be required

Repair clitoral and paraurethral tears in single or double layers, depending on the depth of the trauma. Interrupted stitches should be used.

Post repair pain relief

- Diclofenac 100mg (PR) is recommended analgesia
- Paracetamol 1 g (PR) if diclofenac is contraindicated

Note the time of the procedure completion in the woman's birth record on eCare. The repair technique and suture material must also be documented.

Appendix 7: LocSSIPs

LocSiPP Intrapartum WHO in the Birthing R

Appendix 8: Looking after your pelvic floor when you have a baby patient information leaflet

Looking after your pelvic floor when you

Appendix 9: Care of your perineum after the birth of your baby patient information leaflet

Perineal care - PIL for approval.docx

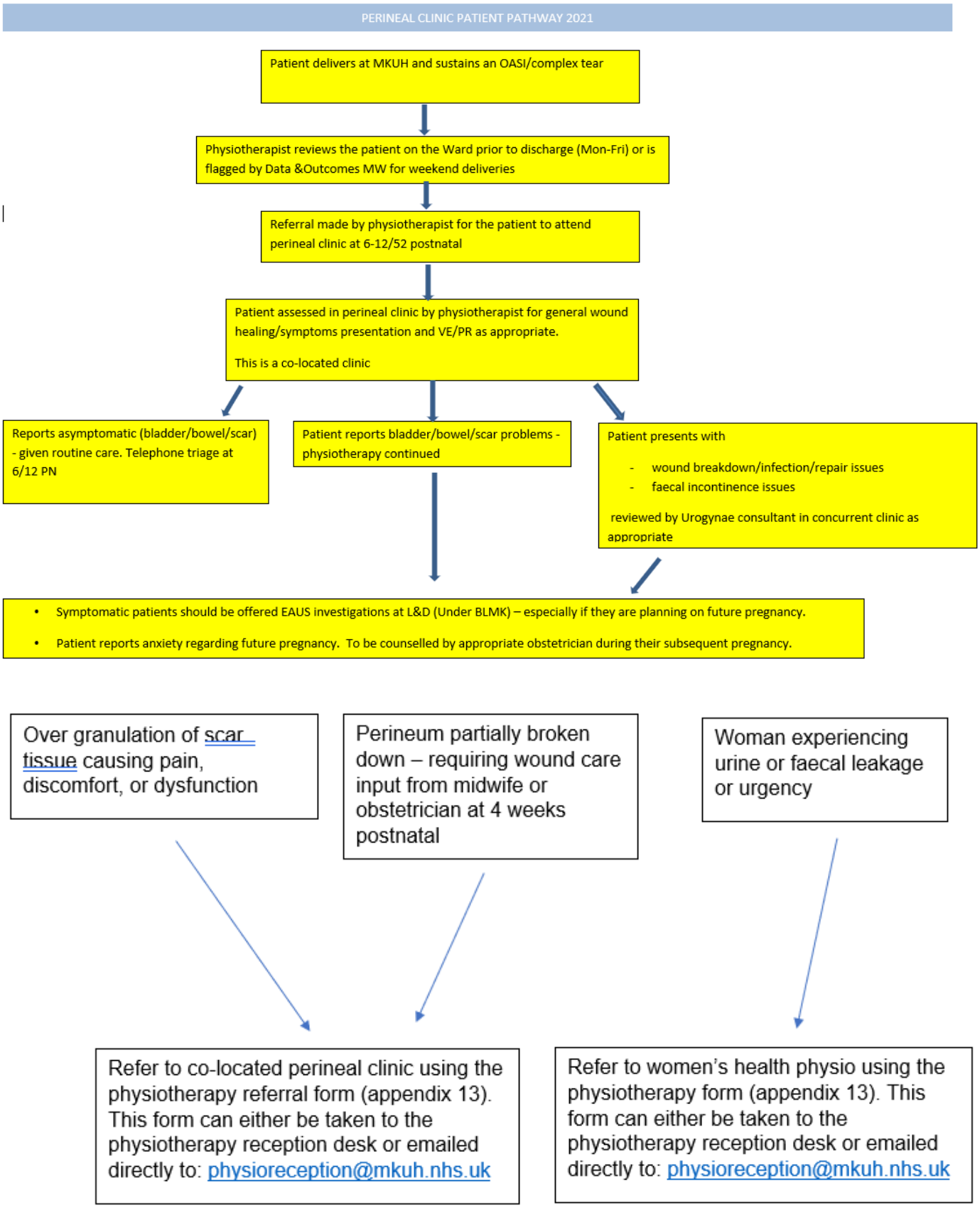
Appendix 10: RCOG 3rd and 4th degree tear patient information leaflet

pi-care-of-third-and-fourth-degree-tears-o

Appendix 11: Getting back into shape after your delivery

Getting back into shape after your deliv

Appendix 12: Referral criteria to the perineal co-located clinic and patient pathway



Appendix 13: Referral form for co-located perineal clinic

Obstetrics and Gynaecological Physiotherapy Referral

Email to physio reception

Obstetrics and Gynaecological Physiotherapy Referral

Surname _____
First Name _____
D.O.B _____
Hospital No _____
Or affix patient label

Patient Name……

Address: ……

……

Patient Telephone Number ……

G.P / Consultant ……

Expected Date of Delivery (antenatal) ……

Date of Delivery (postnatal)……

Relevant Surgery and date ……

Diagnosis / Reason for referral

……

……

……

PMH……

……

……

Interpreter required Yes ☐ No ☐ Language……

X-rays/investigations

……

……

……

……

Signature ……Date……

Print Name ……

Appendix 14: Perineal repair proficiency

Perineal repair proficiency pack 2021