Worcestershire Acute Hospitals NHS Trust

Perineal Tears and Repairs

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the management of perineal tears, suturing and management of OASI.

This guideline is for use by the following staff groups:
Staff undertaking perineal inspection or suturing.

Lead Clinician(s)

Laura Veal	Consultant Obstetrician
Approved by *Maternity Governance Meeting* on:	15th February 2023
Approved by Medicines Safety Committee on: *Where medicines included in guideline*	13th December 2023
Review Date: This is the most current document and should be used until a revised version is in place	13th December 2023

Key amendments to this guideline

Date	Amendment	Approved by:
17th Feb 2023	Consultant to be present for all fourth degree tear repairs. Repair of fourth degree tears changed to vicryl from vicryl rapide. No anal manometry available within region	MGM

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Introduction

Repair of perineal tears should be performed to reduce the long term morbidity of the women. Currently there is no evidence to support not repairing 2nd degree tears. The practice of leaving first and second degree perineal tears unsutured is associated with poorer wound healing and short-term discomfort. Therefore this Trust recommends all women who sustain 2nd degree tear should have their perineum repaired. If suturing is not undertaken clear documentation should reflect the reason why.

The principles of perineal repair apply to women who deliver in hospital or at home.

If the community midwife feels a perineal repair can't be undertaken safely in the home she should contact delivery suite and arrange for transfer in.

Guideline

Definition of degree of tear

First degree Injury to perineal skin only.

Second degree Injury to perineum involving perineal muscles but not involving the anal sphincter.

Third degree * Injury to perineum involving the anal sphincter complex:
3a: Less than 50% of EAS thickness torn.
3b: More than 50% of EAS thickness torn.
3c: Both EAS and IAS torn.

Fourth degree * Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium.

*Must be sutured by appropriately trained personnel who have successfully completed the RCOG approved workshop on repair of 3rd and 4th degree tear. A consultant must be in attendance for repair of a fourth degree tear as per RCOG recommendations.

Perineal Repair 1° and 2° Tear

Perineal repair is the responsibility of qualified medical staff and midwives. It should only be performed by staff that have been trained and supervised until they are fully competent.

1. Having explained the procedure, gained and documented verbal consent on BadgerNet the repair should be performed as soon as possible after delivery to minimise blood loss and discomfort, except following waterbirths where it is recommended to wait 30 minutes.
2. Adequate analgesia is essential. 1% Lidocaine infiltration is recommended. The dose of 1% plain lidocaine is 4milligrams/kilogram or maximum of 300 milligrams for 70kilogram patient. Additional infiltration may be required for an episiotomy.
3. Count of swabs instruments and needles to be undertaken by two people <u>before</u> procedure and recorded on BadgerNet A full examination, per vaginum and per rectum, to determine the extent of the tissue damage should be performed. If there is any doubt to the extent of the tear the midwife must ask for a second opinion and abandon the repair if necessary.The repair should be undertaken from a clean surface. Adequate lighting is essential. The woman should be in the most appropriate position, in hospital this will probably be lithotomy. At home the community midwife needs to ensure whichever position the woman is in is safe for the woman and midwife and allows adequate access and vision of the perineum.
4. A lithotomy pack should be used with the woman appropriately draped to assist in maintaining a "clean" area to work from.

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5. Vicryl 2.0 rapide should be used routinely for the repair. The reason for using any different suture material should be clearly documented. The apex must be visualised and the posterior vaginal wall and muscle layer repaired using a continuous stitch. The rationale behind the continuous technique is that stitch tension due to reactionary oedema is transferred throughout the whole length of the single knotless suture in comparison to interrupted stitches, which are placed transversely across the wound.
6. Subcuticular suture to skin is preferred method. Interrupted may be used if there is clinical need or the clinician is untrained in subcuticular suturing.

At the end of the procedure:

- Remove any pack if used from the vagina.
- Perform a vaginal examination to check haemostasis and correct anatomical alignment has been achieved and that the introitus is not too tight.
- Perform a rectal examination to check that sutures have not penetrated the rectal mucosa and that sphincter function is present.
- Count swabs and needles, and dispose of these safely - the count should be undertaken by two people and completed on BadgerNet or locally agreed documentation (i.e. MLU/homebirth)
- Ensure the woman is comfortable and explain the repair.
- Advice should be given regarding care of the perineum including pelvic floor exercises and hygiene and documented on BadgerNet
- Administer analgesia as appropriate (e.g. Diclofenac suppository 100milligrams PR)
- Ensure infiltration and description of repair is recorded in BadgerNet

Management of 3° and 4° Tear

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 and recorded on BadgerNet

The woman should be fully informed about the nature of her injury and the benefits to her of follow-up. Having explained the procedure and gained consent from the woman the repair should be performed as soon as possible after delivery to minimise blood loss and discomfort. Evidence of this should be recorded on BadgerNet

There is a steady increase in litigation related to obstetric anal sphincter injury. The majority are related to failure to identify the injury after delivery, leading to subsequent anal incontinence and rectovaginal fistulae. (RCOG 2007)

- This procedure must be carried out by a medical practitioner that has successfully completed the RCOG approved workshop on repair of 3rd and 4th degree tear or supervised by a consultant.
- For a fourth degree tear repair the consultant must be in attendance and present in theatre,
- Repair in an operating theatre will allow the repair to be performed under aseptic conditions with appropriate instruments, adequate light and an assistant.
- Regional or general anaesthesia will allow the anal sphincter to relax, which is essential to retrieve the retracted torn ends of the anal sphincter. This also allows the ends of the sphincter to be brought together without any tension.
- A full examination to determine the extent of the tissue damage should be performed and include both a VE **and** PR after suturing.

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- Technique: Either end to end or overlap repair is acceptable. End to end technique will be easier for partial tears of the EAS.

2.0 Vicryl to repair anal mucosa

2.0 or 3.0 PDS to repair anal sphincter. The rest of tear sutured as normal repair as mentioned above.

At the end of the procedure

- Give prophylactic IV antibiotic – 1.2 grams co-amoxiclav unless penicillin allergic. If patient known to be severely penicillin allergic i.e. anaphylaxis discuss with consultant microbiologist.
- Ensure adequate analgesia post delivery. Avoid the use of codeine if possible as it is a constipating agent.
- Complete Datix form for all 4th degree tears

Management in the Postnatal Period

- Encourage oral fluids.
- Encourage adequate fiber in diet
- Prescribe a postnatal laxative e.g. Lactulose 10 – 15 milliliters twice daily for 10 days. There is no evidence for also using Ispaghula Husk (e.g. Fybogel®).
- Perineal checks should be performed by midwife and advice given re hygiene.
- A referral should be made to physiotherapy and 'Pelvic Floor After Pregnancy Clinic' via Badgernet.

- Postnatal Ward Physiotherapists will review patients on the ward (Monday to Friday 08:30-10:30) so please highlight these patients to them at handover. Outside of these hours please refer patient to physiotherapy on BadgerNet stating patient not seen on the ward.

- Refer to postnatal physiotherapist highlighting review required following 3rd or 4th degree tear via BadgerNet:
  - Physios will arrange an appointment for patient at 6 weeks postnatal to assess pelvic floor function
  - Patients will be reviewed by a specialist physiotherapist at 3 months (or before if symptomatic) to assess pelvic floor function.
  - Consultant/specialist physiotherapist follow up can be expedited if necessary

- All patients with 3rd or 4th degree perineal tears will receive an appointment to attend the Pelvic Floor After Pregnancy Clinic at 12-24 weeks postnatal depending on clinical need (or before if clinically indicated)
- A timely and documented explanation should be provided to ensure the woman is fully informed of the extent of the tear and likely or possibly contributory factors.

Management of women returning with problems relating to any type of perineal repair

Review by medical staff.

If re-admitted, Consultant Obstetrician should be involved with this decision and ongoing plan of care. A Datix-web incident form should be completed.

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Management of women with a previous 3rd degree tear in a subsequent pregnancy
Patients with a previous 3rd/4th degree tear are at increased risk of a recurrent 3rd/4th degree tear. The risk of a recurrent 3rd/4th degree tear is quoted to be 5-7%.

We do not have facilities for endoanal ultrasound or anorectal manometry at WAHT.

a) BOOKING VISIT – See Consultant:

First enquire about anorectal symptoms:
Faecal urgency, flatal and/or faecal leakage

1) Asymptomatic (with none of the above symptoms at any time following previous tear)
May be suitable for vaginal delivery

Options for discussion with patient:

1: Vaginal birth - explaining risk of recurrent 3rd or 4th degree tear.

2: Caesarean Section - explaining risks of caesarean section as well as explaining that caesarean section may not absolutely protect against later bowel symptoms as pregnancy alone can cause deterioration in anal sphincter control.

If patient very keen on vaginal delivery refer for endoanal ultrasound scan (lead Consultant/Gynaecologist to determine efficacy and arrange scan). (Not currently available in the region at date of update 17/2//23)

If patient wishes caesarean section, plan elective caesarean section as mode of delivery after 39/40.

If patient undecided, review 2-4 weeks in antenatal clinic by Consultant or consider refer to Pelvic Floor After Pregnancy Clinic for further discussion.

2) Symptomatic
Significant risk of deterioration of symptoms following subsequent vaginal delivery.

Offer elective caesarean section after 39/40, explain risks of caesarean section as well as explaining that caesarean section may not absolutely protect against later bowel symptoms as pregnancy alone can cause deterioration in anal sphincter control.

3) Severely symptomatic
Counsel carefully. **The damage is done already. Consider vaginal delivery** and later referral to colorectal for further treatment of bowel symptoms. Patient may still request elective caesarean section after 39/40.

4) Previous elective secondary sphincter repair following pregnancy:
Not suitable for vaginal delivery. **Offer elective LSCS**

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b) FOLLOW UP ANTENATAL VISIT
See Consultant if mode of delivery not yet confirmed
Review endoanal ultrasound scan and manometry results

Offer Elective Caesarean Section if abnormal endoanal scan (i.e. >25% sphincter defect) +/- abnormal manometry (i.e. squeeze pressure increment <20mmHg)

Support patient if still wishing vaginal delivery

c) 36/40 FOLLOW UP IN ANTENATAL CLINIC
Any patient planning a vaginal delivery after a 3rd or 4th degree tear should be seen by the consultant in Antenatal Clinic at 36/40 to ensure vaginal delivery is still appropriate.

Management of women with anorectal symptoms in the absence of a history of 3rd degree tear
Refer to colorectal surgeons and manage pregnancy as above.

Management of women with a previous 3rd degree tear in a subsequent labour
The birth should be facilitated by an experienced midwife, not a junior student midwife, however it is recognized that a student midwife would benefit from providing effective, supportive care for these women.

Elective episiotomy is NOT indicated, only if clinically indicated at time of crowning.

Perineal repair should be done by an experienced practitioner with careful attention to the integrity of the EAS.

Patients attending in labour with an elective caesarean booked for previous 3rd degree tear should not be encouraged to attempt a vaginal birth. Caesarean section should be performed as an emergency procedure.

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References

Royal College of Obstetrics and Gynaecologists. (2015). *Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29)*. [Online]. RCOG. Last Updated: June 2015. Available at: rcog perineal repair guideline - Search (bing.com)Available at:

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Governance Meeting
Medicines Safety Comittee

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