PERINEAL TRAUMA
(TEARS AND EPISIOTOMY)

INTRODUCTION
- Perineal trauma may occur spontaneously during vaginal birth or by a surgical incision (episiotomy). It is possible to have an episiotomy and a spontaneous tear (for example, an episiotomy may extend into a third-degree tear)
- Over 85% of women who have a vaginal birth will sustain some degree of perineal trauma and of these 60–70% experience suturing

DEFINITION
Anterior perineal trauma
Injury to labia, anterior vagina, urethra or clitoris

Posterior perineal trauma
Injury to posterior vaginal wall, perineal muscles or anal sphincters – may include disruption of the anal epithelium

Classification of perineal tears
Midwife/doctor must identify the extent of perineal trauma and document it according to the agreed classification

Definition of spontaneous tears

<table>
<thead>
<tr>
<th>First degree</th>
<th>Second degree</th>
<th>Third degree</th>
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<tbody>
<tr>
<td>Injury to skin only</td>
<td>Injury to perineum involving perineal muscles but not involving anal sphincter</td>
<td>Injury to perineum involving anal sphincter complex</td>
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<tr>
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<td>3a: &lt;50% of external anal sphincter (EAS) thickness torn</td>
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<td>3b: &gt;50% of EAS thickness torn</td>
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<td>3c: EAS and internal anal sphincter (IAS) torn</td>
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See also Third and fourth degree perineal tears guideline

PRINCIPLES OF REPAIR
- All women receive a systematic assessment of the perineum, vagina and rectum and return for an accurate evaluation of any trauma sustained
- Give clear information regarding the extent of perineal trauma sustained, and how and when to seek advice if problems occur

Initial assessment
- Explain what is planned and why
- Offer entonox
- Ensure good lighting
- Place woman in comfortable position with genital structures clearly visible
- Perform initial examination gently and with sensitivity immediately after birth
- If genital trauma identified, carry out further systematic assessment including a rectal examination

Systematic assessment
- Further explain what is planned and why
- Timing of systematic assessment should not interfere with mother-infant bonding unless bleeding requires urgent attention
- Check equipment and count swabs before commencing procedure and count again following completion of repair
Lithotomy is the usual position to allow adequate visual assessment of the degree of trauma and for the repair. Maintain this position only as long as necessary for assessment and repair.

Confirm effective local or regional analgesia in place. Up to 20 mL lidocaine 1% can be used.

Assess trauma visually (with good lighting) including structures involved, apex of injury and degree of bleeding.

Perform rectal examination to identify damage to the external or internal anal sphincter.

**Documentation**
- Clearly document in maternal healthcare record:
  - examination findings, using agreed classification above, consider using a diagram
  - if rectal examination performed as part of initial assessment
  - if rectal examination was not carried out and reasons for not doing so

**Perineal suturing**

**Consent**
- Explain procedure, obtain and record consent
- Women who refuse to be examined and decline perineal repair must be given the opportunity to discuss their concerns with the person providing care. Discussion should include information about the potential risks which may occur if trauma to the sphincters remains undetected
- Ensure discussion is clearly documented

**Equipment**
- Suture pack
- Sterile gown and gloves
- Protective glasses
- Cleansing solution or sterile water
- Suture material – vicryl rapide 2/0 (or equivalent) on a 35 mm taper cut needle
- 10–20 mL syringe and green needle
- Obstetric cream
- Local anaesthetic – lidocaine 1% up to 20 mL. If more required, consider spinal anaesthetic
- Adequate lighting
- Drapes

**Procedure**
- A difficult trauma must be repaired by an experienced obstetrician in theatre under regional or general anaesthesia
- Suture as soon as possible following delivery to reduce blood loss and risk of infection, except in women who have laboured in the pool or had a water birth, in which case, suture after an hour
- Use an aseptic technique
- If woman reports inadequate pain relief, provide immediately
- Ensure good anatomical alignment of the wound and give consideration to the cosmetic result
- Use a continuous non-locked suturing technique for the vaginal wall and muscle
- If skin is opposed following muscle suturing it is not necessary to suture it
- Where skin does require suturing use a continuous subcuticular technique
- Suture first degree tears unless edges are well opposed
- On completion of repair, perform further rectal examination to exclude any suture material inserted through rectal mucosa
- Unless contraindicated, administer diclofenac (Voltarol) 100 mg rectally

**After repair**
- Before and after suturing, perform and document a two-person swab, needle and instrument check. Be particularly vigilant if there is heavy bleeding, a change of operator or transfer to theatre
If a vaginal pack is left *in situ*, document and communicate via handover
- Ensure safe disposal of all equipment in accordance with local Trust policy and COSHH regulations
- Document nature of trauma and method of repair
- Unless contraindicated, prescribe and administer pain relief, usually diclofenac suppositories
- Advise woman about diet, hygiene and the importance of pelvic floor exercises

**Problems with perineum after discharge from hospital**
- If GP or community midwife concerned about a woman’s perineum they should refer her urgently to the maternity unit or perineal trauma clinic