REPAIR OF THIRD AND FOURTH DEGREE PERINEAL TEARS
Supporting information

This guideline has been prepared with reference to the following:
Royal College of Obstetricians and Gynaecologists. The management of third- and fourth-degree perineal tears, 2nd ed. London: RCOG, 2007 (Green-top Guideline No. 29)

Does midline episiotomy constitute a risk factor for third degree tears?
A Cochrane systematic review (Carroli, 2009) failed to answer this question. The three published trials available (Werner, 1991; Coats, 1980; Detlefsen, 1980) were held to be “of poor methodological quality, making their results uninterpretable” and were thus excluded from the review. Nonetheless, RCOG guidelines (see above) recommend mediolateral episiotomy in order to reduce the risk of third degree tears.


Evidence Level: I (Inconclusive)

Do anal sphincter tears need to be repaired immediately?
A randomised controlled trial in 165 women (Nordenstam, 2008) allocated 78 to immediate operation and 87 to delayed (8-12 hours) repair. Functional outcome was the same at 1-year follow-up. Delayed repair was not recommended routinely, but, if unavoidable, did not appear to prejudice outcome.


Evidence Level: II

Does antibiotic prophylaxis at the time of repair help to prevent infection?
A randomised, placebo-controlled trial in 147 patients (Duggal, 2008) allocated 83 to placebo and 64 to antibiotics. There were 40 drop-outs (27.2%). At 2 weeks postpartum, 4 of 49 (8.2%) patients who received antibiotics and 14 of 58 (24.1%) patients who received placebo developed a perineal wound infection (P=.037). Antibiotic prophylaxis is recommended in RCOG guidelines (see above).
A Cochrane review (Buppasiri, 2005) had previously called for a suitable trial after finding insufficient evidence with which to address this question.


Evidence Level: II

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Are continuous or interrupted suturing techniques indicated for perineal repair?
A Cochrane review of 7 studies in 3822 women (Kettle, 2007) found that continuous sutures compared with interrupted sutures were associated with less pain for up to 10 days postpartum (RR 0.70, 95% CI 0.64 - 0.76). Subgroup analysis showed greater reduction in pain when continuous suturing techniques were used for all layers (RR 0.65, 95% CI 0.60 - 0.71).


Evidence Level: I

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