<table>
<thead>
<tr>
<th>This is an official Northern Trust policy and should not be edited in any way</th>
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<tr>
<td><strong>Perineal Repair following Delivery</strong></td>
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<tr>
<td>Reference Number:</td>
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<tr>
<td>NHSCT/10/305</td>
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<tr>
<td>Target audience:</td>
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<tr>
<td>Midwives and Obstetricians</td>
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<tr>
<td>Sources of advice in relation to this document:</td>
</tr>
<tr>
<td>Gillian Morrow, Practice Development Midwife</td>
</tr>
<tr>
<td>Gwyneth Peden, Clinical Governance Midwife</td>
</tr>
<tr>
<td>Replaces (if appropriate):</td>
</tr>
<tr>
<td>Guidelines for Midwives and Medical Staff when carrying out Perineal Repair (1998) United Hospitals</td>
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<tr>
<td>Guidance to midwives in the administration of local anaesthesia for suturing of the perineum and undertaking episiotomy (1996) United Hospitals</td>
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<tr>
<td>Type of Document:</td>
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<td>Directorate Specific</td>
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<tr>
<td>Approved by: Policy, Standards and Guidelines Committee</td>
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<td>Date Issued by Policy Unit: 7 July 2010</td>
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**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
Perineal Repair following Delivery
Perineal Repair following Delivery

Relevant to
All midwives and obstetricians

Purpose
To provide guidance for midwives and obstetricians carrying out perineal repair

Objectives
That the practitioner is able to carry out the repair competently and their practice is based on the most recent evidence and recommendations

Background
Perineal trauma can occur spontaneously during vaginal birth, caused by trauma during an assisted delivery or by a surgical incision (episiotomy). Approximately 85% of women will sustain some degree of perineal trauma and approximately 70% will require perineal suturing, following vaginal delivery.

Perineal damage can have a major adverse impact on women’s short and long term health.

The assessment and management of perineal trauma is a routine part of maternity care and there is evidence that practitioners who are appropriately trained are more likely to provide a consistent high standard of perineal care.

Definitions/Classification

First degree
Involves injury to the skin only.

Second degree
In addition to skin injury, involves perineal muscles but not the anal sphincter.

Third degree
Injury to the perineum involving the anal sphinter complex, 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

Fourth degree
Injury to the perineum involving the anal sphincter complex (EAS and IAS) and ano-rectal epithelium.
Episiotomy
A surgical incision of the perineum to enlarge the vulval outlet.
Consider if:
1. Complicated vaginal delivery including breech, shoulder dystocia or instrumental.
2. To expedite delivery when the presenting part is distending the perineum and there is evidence of non-reassuring fetal heart rate pattern.
3. Following previous major surgical repair of the pelvic floor, scarring or poor healing.
4. Other medical or obstetric reason e.g. cardiac disease.

Procedure
Repair should occur as soon as possible to minimise the risk of blood loss and infection but should not interfere with maternal-child bonding.

Assessment
Prior to assessment the practitioner will:
• Explain to the woman the procedure and its importance
• Ensure the woman has adequate analgesia
• Ensure good lighting
• Position the woman so that she is comfortable and so that the genital structures can be easily visualised
The initial assessment should be performed gently and sensitively.
Visual assessment of the extent of the trauma should include the structures involved, the apex of the injury and assessment of bleeding.
A rectal examination should be performed to assess damage to the perineal and anal muscles.
If there is uncertainty about the nature or extent of trauma sustained or suspected 3rd or 4th degree trauma, referral should be made to an obstetric registrar or consultant.
(Refer to NHSCT Guideline for the management of third and fourth degree tears)

Non-Suturing
Practitioners should be cautious about leaving perineal trauma unsutured and should document if the woman declines to be sutured.
The practice of leaving 2nd degree perineal tears unsutured is associated with poorer wound healing and non significant differences in short-term discomfort. However more good evidence is required to inform clinical practice regarding the short and long term effects associated with suturing versus non-suturing.
Preparation
Fully explain procedure to the woman
Offer /obtain chaperone
Place mother in comfortable position, allowing good visualisation for practitioner
Baby can continue skin to skin contact throughout the procedure
Perineal trauma should be repaired using aseptic technique
Perineal repair should only be undertaken when tested effective analgesia is in place
If the woman has an epidural ensure it provides adequate pain relief. If it does not, then local anaesthesia may be used in addition.

Materials/Equipment
- Sterile drape
- Sterile gown and gloves
- Gauze swabs and tampon
- Needle holder
- Scissors
- Toothed forceps
- 20ml syringe and needle
- 20mls Lignocaine 1%
- Suture material (recommended that absorbable synthetic suture material is used for perineal repair)
- PR analgesia if required

Method of repair
- Practitioner should ‘scrub-up’
- Wash vulval/perineal area and drape with sterile drapes
- A swab, needle and instrument check should be performed
- Inspect vagina for tissue trauma and assess degree of tear, then identify the apex of the tear/episiotomy
- Infiltrate area with 1% Lignocaine up to a total of 20mls (to include any Lignocaine 1% given for infiltration at delivery)
  - Lignocaine ampoule must be checked with a second person
  - Draw back to ensure no venous infiltration
  - Allow time for local anaesthetic to become effective
- A gauze maternity tampon may be inserted into the upper vagina, above the trauma to absorb any bleeding from the uterus, which may obscure the field of operation.
- The tape of the tampon is secured to the sterile drape
Vagina

- Visualise the apex of the wound and insert anchor suture approximately 0.5cm above this point
- Repair the vaginal wall using a continuous non-locking stitch with approximately 0.5cm between each stitch
- Continue to suture until the hymenal remnants are reached ensuring sutures are not placed in the hymenal remnants
- Place the needle behind the hymenal remnants and emerge in the centre of the perineal muscle

Perineal muscles

- Check the depth of trauma
- Repair the perineal muscles in one or two layers with the same continuous stitch
- Ensure the muscle edges are apposed carefully leaving no dead space
- Visualise the needle between sides to prevent stitches being inserted into the rectal mucosa
- On completion of the muscle layer, the skin edges should align so that they can be brought together without tension
Skin

- Reposition the needle
- At the inferior end of the wound commence suturing the skin from the apex of the wound
- Stitches are placed below the surface of the skin, the point of the needle should be repositioned between each side, so that it faces the skin edge being sutured
- Continue taking bites of tissue from each side until the superior wound edge is reached
- Sweep the needle behind the fourchette back into the vagina. Pick up a small amount of vaginal tissue to tie off the stitch and cut (the knot is tucked into the vagina to minimise discomfort)

Immediate post operative care

Inspect the repair and check that haemostasis has been achieved

Remove vaginal tampon, if used

Count all swabs, needles and instruments and document (using Appendix 1)

Discard sharps safely

Perform rectal examination to detect if any suture material has been accidentally inserted into rectal mucosa

Consider the use of PR analgesia, if not contraindicated

Remove woman's legs from lithotomy position and ensure her comfort

Complete documentation in the Maternity Hand Held Record (see Appendix 1) and sign prescription kardex for medications administered

Explain to woman extent of trauma and advise regarding hygiene, pain relief and pelvic floor exercises
References


5. Royal College of Midwives (RCM) Evidence-based guidelines for midwifery-led care in labour. (see page 71, care of the perineum practice points see page 81, suturing the perineum). Available at: www.rcm.org.uk/index.php


## Repair of Perineum

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
<th>Repaired by:</th>
<th>Status:</th>
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<tbody>
<tr>
<td></td>
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<td>Supervisor:</td>
<td>Status:</td>
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### Perineal Trauma Type
- **Perineum Intact**
- **Episiotomy**
- **Indication:**
  - **Labial Laceration**
  - **Tear**

<table>
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<tr>
<th>Degree</th>
<th>Description</th>
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<tr>
<td>1st</td>
<td>Laceration which may involve fourchette, vagina &amp; perineal skin. Perineal body intact</td>
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<tr>
<td>2nd</td>
<td>Injury to the perineum involving perineal muscles but not the anal sphincter</td>
</tr>
<tr>
<td>3rd</td>
<td>Injury to the perineum involving the anal sphincter complex</td>
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</table>
  - 3a Less than 50% of External Anal Sphincter thickness torn |
  - 3b More than 50% of External Anal Sphincter thickness torn |
  - 3c Internal Anal Sphincter torn |
| 4th   | Injury to the perineum involving anal sphincter complex and rectal mucosa |

### Anaesthesia:
- **Local**
- **Type:** Spinal
- **Amount:**
- **G.A.**
- **Other:**

### Method of Repair:
- Procedure explained and verbal consent given by mother: **Yes □ No □**

### Haemostasis achieved: **Yes □ No □**

### Swabs:
- **Raytex 10 x 10 cms**
- **No. in pack:**

### Tampon Inserted:
- **Yes □ No □**
- Removed: **Yes □ No □**

### Suture Material Used:
- **Vicryl**
- **Vicryl Rapide**
- **Polydioxanone (PDS)**
- **Other:**

### P.V. Examination Result:

###Diclofenac 100mg given PR:
- **Yes □ No □**

### Advice Given:
- **Hygiene**
- **Diet, including fibre**
- **Pain relief**
- **Pelvic floor exercises**

### Other Comments:

### Final Check:
- **Tick if Correct:**
  - **SWABS □ NEEDLES □ INSTRUMENTS □**

### Signature 1:
- **Status**

### Signature 2:
- **Status**

**Note:** ALL SHARPS TO BE DISPOSED OF IN ACCORDANCE WITH TRUST POLICY