HUTTmaternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Facilitated by: Jo McMullan, CMM	Last reviewed: February 2014
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Vaginal Tears and Episiotomy Guidelines

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose
These guidelines assist practitioners in the repair of vaginal and perineal tears including the reasons for, and the techniques of performing an episiotomy.

Scope
These guidelines apply to HVDHB Surgical, Womens and Children's' health service and HVDHB access holders.

Introduction
It is estimated that 85% of women who give birth vaginally will get some degree of perineal trauma (60-70% of which will require suturing). The trauma can be spontaneous or as a result of episiotomy.

Assessment
Ensure good visualisation of the tear using a good light source, and the women in the lithotomy position if needed. Inspect the vulva and vagina thoroughly, ensuring good visualisation of the apex of the tear. If in doubt about the extent of the tear, seek the advice of a more experienced colleague.

Classifications of tears

First degree tear
Laceration of the vaginal epithelium or perineal skin only, (Most first-degree tears close spontaneously without sutures)

Second degree tear
Involvement of perineal muscles but not the anal sphincter.
All second degree tears need to be sutured, note the perineal tissue may be intact, hiding a vaginal wall tear.

Third degree tear
Disruption of the anal sphincter muscles.
Subdivision of degree
Grade 3a <50% thickness of the external sphincter torn
Grade 3b> 50% thickness of the external sphincter torn
Grade 3c both external and internal sphincter torn

Fourth degree tear

Injury to the perineum involving the external and internal anal sphincter with disruption of the anal epithelium.

If the tear is long and deep through the perineum, inspect to ensure there is no third or fourth degree tear as follows:

Place a gloved finger in the anus

- Gently lift the finger and identify the sphincter
- Feel for the tone and the tightness of the sphincter
- If the sphincter is not injured, change gloves and proceed with the repair.

Repair of second degree tears

Equipment

- Good light source
- Leg rests
- Antiseptic
- Vaginal packs
- Local anaesthetic, syringe and needle
- Sterile scissors and needle holder
- Absorbable sutures are to be used – Vicryl rapide is recommended

Infiltration

- Ensure the woman has never had an adverse reaction to lignocaine or related drugs
- Infiltrate beneath vaginal mucosa, beneath skin of the perineum, and deeply into the perineal muscle using approximately 10-20ml of 1.0% lignocaine solution.
- Aspirate to ensure no blood vessel is penetrated. If blood is returned in the syringe with aspiration, remove the needle, recheck its position carefully, and try again
- Never inject if blood is aspirated. Intravenous lignocaine can cause seizures and death.
- After injecting the anaesthetic, wait 2 minutes. Test the effectiveness of the anaesthetic; if the woman can still feel pain, then wait another 2 minutes before retesting.

Repair

- Continuous subcutaneous technique for perineal skin closure is associated with less short-term pain than interrupted sutures. Two-stage repair with the skin approximated but left unsutured is associated with less dysparenuria at 3 months compared with three-stage repairs (skin sutured).

Repair of extensive second, third or fourth degree tears

- All repairs should be performed by a trained clinician or by a trainee under supervision.
- Extensive second degree, third and fourth degree repairs should be conducted in an operating theatre with a good light source and aseptic conditions.

- General or regional (spinal, epidural, caudal) anaesthesia is an important pre-requisite.
- In fourth degree tears, torn anal epithelium is repaired with interrupted Vicryl 3.0. Knots are tied in the anal lumen.
- The internal sphincter should be identified and any tear should be repaired separately from the external sphincter with interrupted PDS 3.0.
- Torn ends of the external sphincter are identified and grasped with Allis tissue forceps and repaired with end to end or overlapping repair, depending on the clinicians preference, with Vicryl 2.0 or PDS 3.0 (available from OT).
- Close vaginal epithelium with continuous Vicryl rapide.
- Perineal muscles are reconstructed to provide support for the sphincter repair.
- Perineal skin is approximated with Vicryl rapide 2.0/3.0.
- Intravenous antibiotics (cefuroxime 1.5 g and metronidazole 500mg IV) should be given intraoperatively.
- Oral broad Antibiotics for 10 days
- See physiotherapist for Pelvic floor exercises for 6-12 weeks
- Stool softener (lactose, 10 ml, 3 times daily) and bulking agent? Metamucil) is prescribed for at least two weeks postoperatively.
- Ensure adequate analgesia is charted.
- Detailed notes of findings and repairs should be made.
- Follow up appointments for third and fourth degree tears at the hospital secondary care clinic are warranted at 6 weeks.

Instruments required
Speculum
2x Allis tissue forceps
2x artery forceps 6"
Suture scissors
Needle holder
Bonneys toothed dissector
Suture material
Vicryl 2.0/3.0
Vicryl rapide 2.0/3.0
PDS 3.0 (available from OT)

Other equipment
Vaginal pack
10 x gauze swabs
5 x gamgee swabs
Lithotomy guard
Indwelling catheter equipment

Episiotomy
The rates of episiotomy vary widely internationally from 8% in the Netherlands to 99% in Eastern Europe. There is evidence to support the restrictive use of episiotomy compared with the routine use of episiotomy, thus it should only be considered in the case of:
To expedite a rapid delivery in cases of fetal distress

- Scarring from female genital cutting or poorly healed third or fourth degree tears.
- Complicated vaginal delivery (which may include breech, shoulder dystocia, forceps, and ventouse).

Management

- Up to 10ml of 1% xylocaine must be infiltrated into the perineum before making the episiotomy. Adequacy of analgesia should be assessed prior to performing the episiotomy unless in an emergency.
- A right medio-lateral episiotomy (starting at the fourchette) is performed after informed consent obtained from the woman.
- Repair as per second degree tear (or third/fourth tear as appropriate).

Aftercare

- Ensure pain relief is prescribed (analgesia is the pain relief of choice), and stool softener
- Apply intermittent ice packs to the site of the repair (for comfort and to decrease swelling)
- Advise the woman to keep the area clean and dry – shower/bath twice a day and perineal toilet after bowels opened.

Management of infected perineal tears

- A perineal tear is always contaminated with faecal material. If closure is delayed more than 12 hours, infection is inevitable.
- For first and second degree tears, consider leaving the wound open
- Antibiotics as per clinician's preference. For third and fourth degree tears, close the rectal mucosa with some supporting tissue and approximate the fascia of the anal sphincter with 2 or 3 sutures. Close the muscle and vaginal mucosa and the perineal skin 6 days later.

<u>Other complications</u>

- If a haematoma is observed small/ asymptomatic haematomas can be managed conservatively, Large/ symptomatic/ enlarging haematomas need draining. If there are no signs of infection and the bleeding has stopped, the wound can be re-closed. If there are signs of infection, open and drain the wound. Remove infected sutures and debride the wound:
- If the infection is mild, antibiotics are not required
- If the infection is severe, antibiotics charted as per clinician's preference.

Note: faecal incontinence may result from complete sphincter transaction. Many women are able to maintain control of defaecation by use of other perineal muscles. When incontinence persists, reconstructive surgery must be undertaken 3 months or more after delivery. Rectovaginal fistula requires reconstructive surgery 3 months or more postpartum.

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Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix I

Third degree checklist

Analgesia charted	□
Antibiotic cover	□
Laxative charted	□
Referral to physio	□
ACC form completed (if applicable)	□
6 week check appointment made	□
Self-cares explained	□