PERINEAL REPAIR GUIDELINE

1. OPTIMAL OUTCOMES
   • Reduce the adverse impact of perineal trauma on a woman’s health by:
     o Providing adequate haemostasis
     o Obliteration of the dead space
     o Reduction of the risk of developing a haematoma/infection/wound breakdown

2. PATIENT
   • Women requiring repair of perineal trauma other than 3rd & 4th degree tears

3. STAFF
   • Midwife accredited to perform perineal repair
   • Medical staff suitably competent to perform perineal repair

4. EQUIPMENT
   • Light source
   • Leg supports
   • Suture pack
   • Sterile drapes
   • Chlorhexidine 0.02%
   • Abdominal sponges 20X20cms radio opaque
   • Lignocaine 1% / 2%, or Lignocaine 2% with adrenaline 1: 200,000
   • 20ml syringe
   • 23 gauge needle
   • Appropriate absorbable synthetic suture material
   • Personal protective equipment including face protection, gown and double gloves
   • Vaginal tampon with x-ray detectable tail
   • Designated suture trolley

5. CLINICAL PRACTICE
   • Using an aseptic technique suture as soon as possible after birth to reduce the risk of bleeding and infection
   • Perform adequate perineal examination, after consent, usually immediately after delivery of placenta. This will require a rectal examination. If 3rd or 4th degree tear is suspected call the medical officer to inspect the wound before suturing
   • Discuss findings of perineal examination with the woman and her support people, explaining the benefits/risks of perineal repair
   • Adjust bed height or position the woman to prevent occupational hazards from static positions, position the woman to enable adequate access to perform the repair, position the light, drape the woman and maintain privacy
   • Open new drapes and put on new sterile gloves
   • Cleanse perineal area using chlorhexidine or sterile saline
   • Ensure adequate anaesthesia by infiltrating wound with local anaesthetic:
     o Lignocaine 1% without adrenaline maximum dose 20mls (200mg) is the appropriate dose for a 70kg women i.e. 3mg / kg
     o Lignocaine 2% with adrenaline maximum dose 25mls (500mg) is the appropriate dose for a 70kg woman i.e. 7mg / kg
   • Identify the apex before suturing
   • Insert tampon if required and attach tail to drape with forceps
PERINEAL REPAIR GUIDELINE  cont’d

- Commence suturing from above the apex using a continuous suturing technique
- Use interrupted sutures to the perineal body
- Use a subcuticular suturing technique to the skin if the skin is to be closed
- Inspect the vagina, after consent, to ascertain haemostasis achieved and the wound edges are apposed
- Perform rectal examination, after consent; to check no suture material has perforated the rectum. Inform the registrar if this has happened
- Explain perineal hygiene to the woman and expected healing process
- Perform count of sponges and sharps with another staff member when available
- Dispose of sharps appropriately
- Leave the woman in a comfortable clean bed
- Ensure adequate postnatal analgesia is prescribed by a medical officer

6. HAZARDS/SUB-OPTIMAL OUTCOMES

- Haematoma
- Rectovaginal fistula
- Occupational exposure to blood/body fluids
- Retained foreign body
- Dyspareunia

7. DOCUMENTATION

- Partogram
- Integrated notes
- Medication sheet
- Obstet database

8. EDUCATIONAL NOTES

- The rational for midwives performing perineal repair is to provide continuity of caregiver to the woman throughout the intrapartum and immediate postpartum period
- When suturing, forceps or a needle holder should be used to pick up the needle to draw it through the tissue to prevent a needle-stick injury
- If there are any suspicions of a 3rd or 4th degree tear a rectal examination should be done beforehand
- The practice of leaving first and second degree perineal tears unsutured is associated with poorer wound healing and non-significant differences in short term discomfort
- Doses of local anaesthetic are calculated as
  - Lignocaine without adrenaline = 3mg / kg
  - Lignocaine with adrenaline = 7mg / kg
- The dose available is:
  - 1% lignocaine 10mg/ml
  - 2% lignocaine 20mg/ml
- Signs of local anaesthetic toxicity include:
  - Ringing in ears
  - Numb mouth
  - Flicker of the eyes
  - Seizure
  - Hypotensive
  - Collapse/comatose
PERINEAL REPAIR GUIDELINE  cont’d

Lignocaine with adrenaline should not be used to infiltrate peri-clitoral tears

- The use of a continuous subcuticular technique for perineal skin closure is associated with less short-term pain than interrupted sutures
- A loose continuous non-locking suturing technique used to appose each layer, vaginal tissue, perineal muscle and skin is associated with less short-term pain compared with interrupted sutures
- Leaving the skin apposed but not sutured (two layer technique) is associated with an increase in wound gaping up to 10 days following birth but less dyspareunia at 3 months postpartum when compared with suturing the skin
- The Royal Hospital for Women Birthing Services provides perineal repair workshops and an accreditation process for perineal repair. Any midwife or medical officer intending to undertake perineal repair must complete and maintain their accreditation
- Infibulation and re-infibulation is illegal

9. RELATED POLICIES/ PROCEDURES

- Second stage labour care
- The Crimes (Female Genital Mutilation) Act 1995
- Third and fourth degree perineal tears – repair and management
- Aseptic Technique

10. REFERENCES

- C Kettle and RB Johanson (1998) Continuous versus interrupted sutures for perineal repair. The Cochrane Database of Systematic Reviews 1