Approved by Quality & Patient Safety Committee
16/7/15

PERINEAL/GENITAL TRACT REPAIR

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Reduce the adverse impact of genital tract trauma on a woman's health by timely and proficient repair of perineal trauma

2. PATIENT

- Woman requiring repair of genital tract trauma other than 3rd & 4th degree tears

3. STAFF

- Midwives accredited to perform perineal repair
- Medical staff accredited to perform perineal repair

4. EQUIPMENT

- Light source
- Leg supports
- Suture pack
- Sterile drapes
- Chlorhexidine 0.02%
- Abdominal sponges 20X20cm radio-opaque
- Vaginal plugs (tampons) with tails radio-opaque
- Lignocaine 1%
- 23 gauge needle, 20 ml syringe
- Appropriate absorbable synthetic suture material (Vicryl or Vicryl rapide)
- Personal protective equipment (PPE) including face protection, gown and double gloves
- Designated suture trolley or other appropriately clean trolley

5. CLINICAL PRACTICE

- Perform systematic genital tract examination, with consent, immediately after delivery of placenta in woman who has had a vaginal delivery with evidence of genital tract trauma. This may require a rectal examination. If 3rd or 4th degree tear is suspected, call the medical officer to inspect the tear
- Discuss findings of perineal examination with the woman explaining the benefits/risks of perineal repair
- Using an aseptic technique throughout, suture as soon as possible after birth to reduce the risk of bleeding and infection[1]
- Set up equipment on designated suture trolley or other cleaned trolley.
- Adjust bed height or position the woman to prevent occupational hazards. Position the woman and the light to enable adequate access to perform the repair
- Perform instrument, sponge and needle count with 2nd staff member
- Time out performed to confirm patient, consent and procedure
- Cleanse perineal area using Chlorhexidine 0.2%
- Drape the woman and maintain privacy

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- Infiltrate the perineal area with local anesthetic as required (excluding allergies and contraindications for use)
    - Lignocaine 1% without adrenaline maximum dose 20mls (200mg) is the appropriate dose for a 70kg women i.e. 3mg / kg
    - Ascertain effectiveness of analgesia before commencing suturing
- Commence suturing from above the apex to introitus using a continuous non-locking suturing technique using an absorbable suture
- Insert vaginal plug into vagina to optimize visual access. Only vaginal plugs are to be inserted into vaginal orifice with artery forceps attached to tail. This clearly identifies the presence of the vaginal plug to markedly reduce the risk of them being left behind at conclusion of procedure.
- Repair perineal muscle with a continuous non locking suture for haemostasis and approximation of tissues.
- Appose perineal skin edges with sub-cuticular suture
- Inspect the vagina, after obtaining consent
- Remove vaginal plug using gentle traction
- Perform rectal examination, with 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
- Check fundus and blood loss
- Perform count of instruments, sponges, vaginal plugs and sharps with second staff member and document
- Dispose of sharps appropriately
- Ensure the woman is in a comfortable clean bed and adequate postnatal analgesia is prescribed by a medical officer
- Offer woman analgesia (oral or rectal)
- Write up any local analgesia on medication chart and have signed by a medical officer

6. DOCUMENTATION

- Partogram
- Integrated clinical notes
- Medication chart
- ObstetriX

7. EDUCATIONAL NOTES

- Approximately 70% of women will experience perineal trauma after vaginal birth Perineal or genital trauma caused by either tearing or episiotomy should be defined as follows:
    - first degree – injury to skin only
    - second degree – injury to the perineal muscles but not the anal sphincter
    - third degree – injury to the perineum involving the anal sphincter complex:
        - 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.
    - fourth degree – injury to the perineum involving the anal sphincter complex (external and internal anal sphincter) and anal epithelium
    - An episiotomy is an incision made in the perineum immediately prior to birth to enlarge vaginal outlet or expedite delivery. An episiotomy involves vaginal mucosa, deep and superficial muscles and perineal skin.

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- There are limited studies comparing non suturing first and second degree tears with suturing and these studies only looked at short term outcomes[3].The practice of leaving first and second degree perineal tears unsutured may be associated with poorer wound healing and non-significant differences in short term discomfort. In general with second degree tears, the perineal muscle as a minimum should be sutured.
- Signs of local anaesthetic toxicity include :
    - Ringing in ears
    - Numb mouth
    - Flicker of the eyes
    - Seizure
    - Hypotension
    - Collapse or coma
- Lignocaine with adrenaline should not be used.
- Meta-analysis showed that continuous suture techniques compared with interrupted sutures for perineal closure (all layers or perineal skin only) are associated with less pain for up to 10 days' postpartum (risk ratio (RR) 0.76; 95%confidence interval (CI) 0.66 to 0.88, nine trials). There was an overall reduction in analgesia use associated with the continuous subcutaneous technique versus interrupted stitches for repair of perineal skin (RR 0.70; 95% CI 0.59 to 0.84).
- A continuous non locking suture should be used for all laye4. It may be possible to repair perineal mucosa, perineal muscle and perineal skin edges with the same continuous suture
- Absorbable sutures should be used. In a meta-analysis catgut has been associated with more short term pain than synthetic absorbable sutures. There were few differences between standard absorbing synthetic sutures such as polyglactin (Vicryl®) and rapidly absorbing synthetic sutures**.**
- There is limited evidence for the use of local cooling with ice or cool packs to prevent pain[6]
- Rectal analgesia is associated with less pain in the 24 hours after childbirth and less need for additional analgesia and NSAIDS should be considered if not contra-indicated[7]
- 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 (female genital mutilation) and re-infibulation is criminalised by State and Territory laws[8]

8. RELATED POLICIES/ PROCEDURES/LOCAL OPERATING PROCEDURES

- Second Stage of Labour Care recognition of normal progress and management of delay
- Third and fourth degree perineal tears – repair and management
- Accountable Items in the Birthing Environment (outside operating theatre) Guideline
- Aseptic Technique
- Vaginal examination in labour
- Instrumental Vaginal delivery
- Postpartum haemorrhage- prevention and management[5]

9. RISK RATING

- Low

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10. REFERENCES

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8. The Royal Australian College of Obstetricians and Gynaecologists. Female Genital Mutilation. Information for Australian health professionals1997.

REVISION & APPROVAL HISTORY

Reviewed and endorsed Maternity Services LOPs July 2015
Approved Quality & Patient Safety Committee 19/9/2013
Reviewed and endorsed Maternity Services LOPs 10/9/13
Approved Quality & Patient Safety Committee 20/6/13
Reviewed June 2013
Minor additions September 2012 & November 2012
Approved Patient Care Committee 6/12/07
Reviewed November 2007 following clinical incident
Approved Quality Council 16/10/06
Maternity Services Clinical Committee 12/9/06

FOR REVIEW : JULY 2020