



Aneurin Bevan University Health Board

Guideline for the Management of Third and Fourth degree Perineal Tears

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents:

Introduction.....	3
Policy Statement	3
Aims	3
Objectives	3
Scope	3
Roles and Responsibilities.....	3
Training.....	3
Main Guideline	4
References	8
Appendices.....	9

Introduction

This document should act as guideline for the management of third and fourth degree perineal trauma. The views expressed in these guidelines are evidence based from NICE and RCOG guidelines and reflect professional opinion. They are designed to support safe and effective practice.

Policy Statement

A partnership in care, which offers women the optimum opportunity for good maternal and fetal outcomes. Considering at all times the maintenance of dignity and self esteem of the woman.

Cross reference to relevant Standards for Health Services Wales.

Aims

To provide support for clinical decision making.

Objectives

These guidelines are designed to support safe and effective practice.

Roles and Responsibilities

Multidisciplinary communication and documentation is essential.

Training

Staff are expected to access appropriate training where provided. Further training needs will be identified through appraisal and clinical supervision.

Monitoring and Effectiveness

Local service Improvement Plan will guide monitoring and effectiveness.

Guideline

THE MANAGEMENT OF THIRD- AND FOURTH-DEGREE PERINEAL TEARS

Background

Incidence: overall, in the UK, 2.9% (range 0-8%). 6.1% in primiparae, 1.7% in multiparae women.

Risk factors include:

- Nulliparity
- Shoulder dystocia
- Birthweight >4kg
- Occipito-posterior position
- Prolonged second stage of labour
- Instrumental delivery
- Asian ethnicity

However, it can occur with no risk factors

Prevention:

Medio-lateral episiotomies should be considered for all instrumental deliveries at an angle of 60 degrees away from the midline when the perineum is distended. The evidence is conflicting for spontaneous vaginal deliveries.

Identification

All women having a vaginal delivery are at risk of sustaining a third/fourth degree tear. They should, therefore, all be examined systematically, including a digital rectal examination, to assess the severity of damage.

Classification

1 st degree tear	Injury to perineal skin and/or vaginal mucosa only
2 nd degree tear	Injury to perineum involving perineal muscles but not involving the anal sphincter
3 rd degree tears: injury to perineum involving the anal sphincter complex:	
3a	<50% of external sphincter thickness torn
3b	>50% of external sphincter thickness torn
3c	Both external and internal anal sphincters torn
4 th degree tear	Injury to perineum involving the anal sphincter complex (external and internal anal sphincter) and anorectal mucosa

Buttonhole: tear involves only rectal mucosa with an intact anal sphincter complex. (NB if not recognised and repaired, this type of tear may lead to a rectovaginal fistula).

Repair

General principles:

Repair of a third/fourth degree tear should be conducted by an appropriately trained clinician or by a trainee under supervision in theatre under regional/general anaesthesia. Figure of eight sutures should be avoided for anal sphincter complex and anorectal mucosa as they are haemostatic in nature and may cause tissue ischaemia. A digital rectal examination should be performed after any perineal repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa. If a suture is identified it should be removed.

How to suture third/fourth degree tears:

1. Suturing is carried out in the operating theatre, under regional/general anaesthesia.
2. Use the specially prepared perineal pack. (Third degree pack).
3. Identify the anatomy and suture as below (see appendix 1 for detailed repair of sphincter)
 - a. Anorectal mucosa – continuous or interrupted with 3-0 Vicryl
 - b. Internal anal sphincter – end-to-end repair with

- interrupted or mattress sutures using 3-0 PDS
- c. External anal sphincter – if full thickness either overlapping or end-to-end repair; if partial thickness (all 3a and some 3b tears) end-to-end repair using 3-0 PDS
 - d. Bury anal sphincter complex surgical knots beneath the superficial perineal muscles
4. Digital rectal examination to ensure that sutures have not been inadvertently inserted through the anorectal mucosa. If a suture is identified it should be removed.
 5. 1.2g IV co-amoxiclav(I.V Cefuroxime 1.5 g and Metronidazole 500 mg with P.O cefalexin 500mg and Metronidazole 400mgs tds for 7 days if penicillin allergic) as prophylaxis intra-operatively, continued for 7 days orally.
 6. 10 days of lactulose 15mls Twice daily
 7. Document perineal repair – ORMIS theatre op-note and complete third/fourth degree tear proforma. Documentation should include an accurate detailed account covering the extent of the trauma, the anatomical structures involved, method of repair and suture materials used.
 8. Debrief woman and provide written information (appendix 2)
 9. Refer all women for pelvic floor physiotherapy (appendix 3)
 10. Follow-up 6-12 weeks. (appendix 4)

Potential complications / Risk Management

When torn, the ends of the muscle fibres of the external anal sphincter tend to retract under the skin. Failure to recognise the extent of the trauma and to achieve complete repair can lead to long term sequelae such as faecal incontinence or rectovaginal fistula. Tissue is often oedematous and bleeding immediately post-delivery making identification of muscle and repair difficult. Partial damage to the anal sphincter can have as much impact on future continence as complete disruption.

Post-operative management

- Debrief the woman and explain the nature of the injury and the repair performed, including prognosis that 60-80% of women are asymptomatic 12 months following delivery. Support this with written documentation (appendix 2).
- 7 days of broad-spectrum antibiotics such as co-amoxiclav to reduce the risk of post-operative infections and dehiscence.
- A post-operative laxative, such as lactulose for 10 days, is recommended to reduce the risk of wound dehiscence. Bulking agents are no longer recommended. Stress the need to avoid

- constipation – encourage fluids/fibre intake etc.
- Refer for pelvic floor physiotherapy and encourage women to actively participate (appendix 3 for referral).
- Postnatal follow-up 6-12 weeks post-partum.(appendix 4 for referral).
- Advice on hygiene – especially following defecation.
- Advise women of potential for faecal incontinence – encourage women to report any incidence as soon as possible. Where 4th degree tear occurs women are advised to remain in hospital until bowels open.
- Advise women that the effect of the repair may deteriorate over time (even as late as 12 months later) so women must be advised to report any future deterioration to their GP.
- If a woman is experiencing incontinence or pain at follow-up, referral to a specialist gynaecologist or colorectal surgeon should be considered.

Subsequent pregnancies

Options should be discussed at the post-natal check or at booking for the subsequent pregnancy. All women should be counselled about the mode of delivery and this should be clearly documented. This should include counselling regarding the option of an elective caesarean for women who are symptomatic or have abnormal endoanal ultrasonography and/or manometry.

The role of prophylactic episiotomy is unclear, with no definitive evidence that episiotomy reduces the risk of third/fourth degree tears. Therefore, an episiotomy should only be performed if clinically indicated.

References

1. Royal College of Obstetricians and Gynaecologists, 2015. Green-top Guideline No.29: The management of third- and fourth-degree perineal tears. RCOG Press, London
2. NICE clinical guidelines No. 190, 2014. Intrapartum care: Care of healthy women and their babies during childbirth, London UK.

Appendix 1

Repair of sphincter

- The external anal sphincter is grasped with Allis tissue forceps, muscle is mobilised and pulled across. Suture with end-to end technique for all partial thickness (all 3a and some 3b tears); if full thickness either overlapping or end-to-end repair are appropriate using 3-0 PDS.

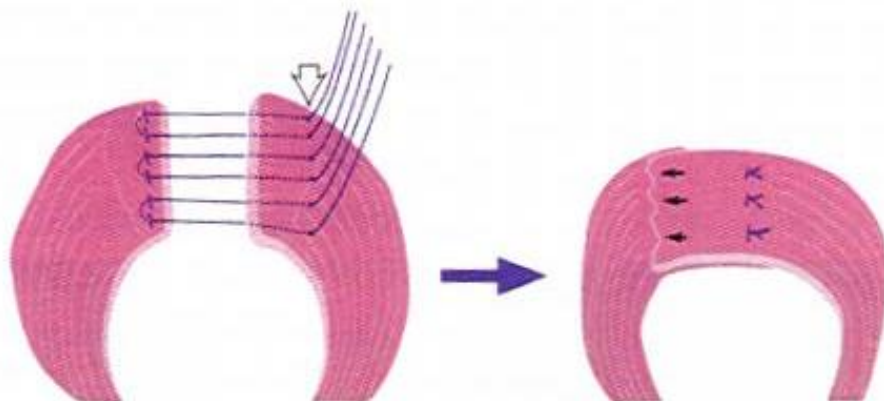


Fig. 5. Diagrammatic illustration to demonstrate the technique of overlap repair of the external anal sphincter. As illustrated, the first suture is inserted about 1.5 cm from the torn edge of the muscle (open arrow) and carried through to within 0.5 cm of the edge of the other arm of external sphincter. A second row of sutures (small arrows) is inserted to attach the loose end of the overlapped muscle.

- The internal anal sphincter is grasped with Allis forceps and repaired end to end with interrupted or mattress sutures using 3-0 PDS.
- Anorectal mucosa is repaired with interrupted or continuous 3/0 Vicryl.
- The vaginal mucosa is sutured with continuous 2-0 vicryl rapide
- The perineal body muscles are sutured with 2-0 vicryl rapide, taking care to bury the knots of the anal sphincter complex repair beneath the superficial perineal muscles to minimize the risk of knot migration.
- Perineal skin is approximated if needed with 2-0 vicryl rapide subcuticular suture.
- Digital rectal examination should be carried out after completing the repair to ensure sutures have not been inadvertently inserted through the anorectal mucosa. If a suture is identified it should be removed.

Appendix 2—Patient information leaflet

A third- or fourth-degree tear during birth (also known as obstetric anal sphincter injury – OASI) (RCOG)

About this information

This information is for you if you want to know more about third- or fourth-degree perineal tears (also known as obstetric anal sphincter injury – OASI). It may be helpful if you are a relative or friend of someone who is in this situation.

What is a perineal tear?

Many women experience tears to some extent during childbirth as the baby stretches the vagina. Most tears occur in the perineum, the area between the vaginal opening and the anus (back passage).

Small, skin-deep tears are known as first-degree tears and usually heal naturally. Tears that are deeper and affect the muscle of the perineum are known as second-degree tears. These usually require stitches.

An episiotomy is a cut made by a doctor or midwife through the vaginal wall and perineum to make more space to deliver the baby.

What is a third- or fourth-degree tear? For some women the tear may be deeper. A tear that also involves the muscle that controls the anus (the anal sphincter) is known as a third-degree tear. If the tear extends further into the lining of the anus or rectum it is known as a fourth-degree tear

How common are third- or fourth-degree tears?

Overall, a third- or fourth-degree tear occurs in about 3 in 100 women having a vaginal birth. It is slightly more common with a first vaginal birth, occurring in 6 in 100 women, compared with 2 in 100 women who have had a vaginal birth previously

What increases my risk of a third- or fourth-degree tear?

These types of tears usually occur unexpectedly during birth and most of the time it is not possible to predict when it will happen. However, it is more likely if:

- this is your first vaginal birth
- you are of South Asian origin

your second stage of labour (the time from when the cervix is fully dilated to birth) is longer than expected.

you require forceps or a ventouse to help the delivery of your baby – see RCOG patient information *Assisted vaginal birth (ventouse or forceps)* (www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps)

one of the baby's shoulders becomes stuck behind your pubic bone, delaying the birth of the baby's body, which is known as shoulder dystocia – see RCOG patient information *Shoulder dystocia*

(www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia)

you have a large baby (over 4 kg or 8 pounds and 13 ounces)

you have had a third- or fourth-degree tear before.

Could anything have been done to prevent this type of tear?

In most instances, a third- or fourth-degree tear cannot be prevented because it cannot be predicted. However, applying a warm compress to the perineum while you are pushing does appear to reduce the chance of a third- or fourth-degree tear. Your midwife or obstetrician may protect the perineum as your baby's head is delivering and this may also help prevent a tear.

It is unclear whether an episiotomy will prevent a third- or fourth-degree tear from occurring during a normal vaginal birth. An episiotomy will only be performed if necessary, and with your consent.

If you have an assisted birth (ventouse or forceps), you are more likely to have an episiotomy as it may reduce the chance of a third- or fourth-degree tear occurring.

What will happen if I have a third- or fourth-degree tear?

If a third- or fourth-degree tear is suspected or confirmed, this will usually be repaired in the operating theatre. Your doctor will talk to you about this and you will be asked to sign a consent form. You will need an epidural or a spinal anaesthetic, although occasionally a general anaesthetic may be necessary.

You may need a drip in your arm to give you fluids until you feel able to eat and drink. You are likely to need a catheter (tube) in your bladder to drain your urine. This is usually kept in until you are able to walk to the toilet.

After the operation you will be:

- offered pain-relieving drugs such as paracetamol, ibuprofen or diclofenac to relieve any pain
- advised to take a course of antibiotics to reduce the risk of infection because the stitches are very close to the anus

advised to take laxatives to make it easier and more comfortable to open your bowels. Once you have opened your bowels and your stitches have been checked to see that they are healing properly, you should be able to go home.

Will I be able to breastfeed?

Yes. None of the treatments offered will prevent you from breastfeeding

What can I expect afterwards?

After having any tear or an episiotomy, it is normal to feel pain or soreness around the tear or cut for two to three weeks after giving birth, particularly when walking or sitting. Passing urine can also cause stinging. Continue to take your painkillers when you go home.

Most of the stitches are dissolvable and the tear or cut should heal within a few weeks, although this can take longer. The stitches can irritate as healing takes place but this is normal. You may notice some stitch material fall out, which is also normal.

To start with, some women feel that they pass wind more easily or need to rush to the toilet to open their bowels. Most women make a good recovery, particularly if the tear is recognised and repaired at the time: 6–8 in 10 women will have no symptoms a year after birth.

What can help me recover?

Keep the area clean. Have a bath or a shower at least once a day and change your sanitary pads regularly (wash your hands both before and after you do so). This will reduce the risk of infection.

You should drink at least 2–3 litres of water every day and eat a healthy balanced diet (fruit, vegetables, cereals, wholemeal bread and pasta). This will ensure that your bowels open regularly and will prevent you from becoming constipated.

Strengthening the muscles around the vagina and anus by doing pelvic floor exercises can help healing. It is important to do pelvic floor exercises as soon as you can after birth. You should be offered physiotherapy advice about pelvic floor exercises to do after surgery.

Looking after a newborn baby and recovering from an operation for a perineal tear can be hard. Support from family and friends can help.

When should I seek medical advice after I go home?

You should contact your midwife or general practitioner if:

your stitches become more painful or smelly – this may be a sign of an infection
you cannot control your bowels or flatus (passing wind).

Talk to your GP if you have any other worries or concerns. You can be referred back to the hospital before your follow-up appointment if you wish.

When can I have sex?

In the weeks after having a vaginal birth, many women feel sore, whether they've had a tear or not. If you have had a tear, sex can be uncomfortable for longer. You should wait to have sex until the bleeding has stopped and the tear has healed. This may take several weeks. After that you can have sex when you feel ready to do so.

A small number of women have difficulty having sex and continue to find it painful. Talk to your doctor if this is the case so that you can get the help and support you need. It is possible to conceive a few weeks after your baby is born, even before you have a period. You may wish to talk with your GP or midwife about contraception or visit your local family planning clinic to discuss this.

Your follow-up appointment

You may be offered a follow-up appointment at the hospital 6–12 weeks after you have had your baby to check that your stitches have healed properly. You will be asked questions about whether you have any problems controlling your bowels. You may be referred to a specialist if you do.

You will also have the opportunity to discuss the birth and any concerns that you may have.

Can I have a vaginal birth in the future?

Most women go on to have a straightforward birth after a third- or fourth-degree tear.

However, there is an increased risk of this happening again in a future pregnancy. Between 5 and 7 in 100 women who have had a third- or fourth-degree tear will have a similar tear in a future pregnancy.

You may wish to consider a vaginal delivery if you have recovered well and do not have any symptoms. If you continue to experience symptoms from the third- or fourth-degree tear, you may wish to consider a planned caesarean section.

You will be able to discuss your options for future births at your follow-up appointment or early in your next pregnancy. Your individual circumstances and preferences will be taken into account.

Appendix 3

Maternity Services Postnatal Physiotherapy Pelvic floor Referral Pathway form



Dear Physiotherapist,

We are referring this lady for physiotherapy following her delivery as a part of Pelvic Floor Referral Pathway.

**ADDRESSOGRAPH
STICKER**

Delivery Details (tick all boxes relating to delivery):

Date of Delivery _____ Delivery Location _____

Parity: _____

Type of Delivery: _____

Baby Weight(s) : 1. _____

2. _____

Pre existing urine/anal incontinence problems

Post delivery urine/anal incontinence problems

Third degree tear 3a 3b 3c

Fourth degree tear

Thank you

Signature: _____ Name: _____ Date _____

Appendix 4

Maternity Services

Nevill Hall Hospital



Dear Mandy,

We are referring this lady for a three-six month check appointment following her delivery to Mr.Curpad postnatal Clinic.

**ADDRESSOGRAPH
STICKER**

Delivery Details (tick all boxes relating to delivery):

Date of Delivery _____ Ward _____

Primigravida Multigravida

Normal Delivery

Baby Weight(s) 1. _____
2. _____

Pre existing or post delivery
urine/anal incontinence
Problems

Third degree tear

Fourth degree tear

Tick

A referral to Physiotherapy is also required

Signature _____ Date _____

ROYAL GWENT HOSPITAL

POST NATAL FOLLOWUP WITH NAMED CONSULTANT IN 3 MONTHS