

Repair of Perineal Trauma, Episiotomy including Management of 3rd and 4th Degree Tears (Obstetric Anal Sphincter Injuries OASIs) Guideline

Guideline information

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Summary of document:

The guideline aims to ensure appropriate and consistent care and management of perineal trauma. Obstetric anal sphincter injuries (OASI) are caused by perineal trauma during vaginal birth. Long-term morbidity associated with anatomically incorrect approximation of wounds or unrecognised trauma to the external anal sphincter can lead to major physical, psychological, and social problems for the woman.

Scope:

This guideline is for the use of healthcare professionals caring for women who sustain a third or fourth degree perineal tear, also known as obstetric anal sphincter injury (OASI), during childbirth.

From this point forward this guidance uses the term 'woman' (pronouns 'she' or 'her') to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to

the needs of those individuals whose gender identify does not align with the sex that they were assigned at birth.

To be read in conjunction with:

Patient information:

[RCOG leaflet on 3rd and 4th degree tears](#)

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Management of third and fourth degree tears, Patient information, Postnatal Patient information, Subsequent pregnancies, Perineal trauma, OASIs

Glossary of terms

OASIS Obstetric Anal Sphincter Injuries

OP Occipito-posterior

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Scope

This guideline is for the use of healthcare professionals caring for women who sustain a third or fourth degree perineal tear, also known as obstetric anal sphincter injury (OASI), during childbirth.

Aim

The aim of this document is to:

- Support the identification of third and fourth degree perineal tears
- Support the appropriate management of third and fourth degree perineal tears
- Ensure consistent care is provided to women following a third or fourth degree perineal tear

Objectives

The aim of this document will be achieved by the following objectives:

- Correct identification of perineal trauma
- Correct repair of perineal trauma – specifically 3rd and 4th degree tears
- Correct information for women in the postnatal period
- Correct information for women in subsequent pregnancies

Introduction

Obstetric anal sphincter injuries (OASI) are caused by perineal trauma during vaginal birth. Also referred to as third- and fourth-degree perineal tears, these injuries involve the anal sphincter complex and, in more severe cases, anal mucosa. OASI is a leading risk factor for subsequent loss of bowel control (flatus and/or faeces) in women and perineal damage can have a major adverse impact on women's health and mismanagement of perineal trauma is a source of obstetric litigation. Long-term morbidity associated with anatomically incorrect approximation of wounds or unrecognised trauma to the external anal sphincter can lead to major physical, psychological, and social problems for the woman.

Key Points include:

- Midwives and obstetricians should examine all women after birth to assess level of perineal trauma.
- Where a third or fourth degree tear (OASI) is suspected or is obvious women should be referred to a doctor experienced in anal sphincter repair or by a trainee under supervision.
- When assessing the perineum examination should also be done to exclude 'buttonholing'.

Definition of Perineal Tears

GRADE OF TEAR	FEATURES
First degree	Injury to the perineal skin only
Second degree	Injury to the perineal muscles
Third degree	Injury to the perineal muscles AND disruption to the anal sphincter muscles
• Grade 3a	<50% thickness of EAS (external anal sphincter) torn
• Grade 3b	>50% thickness of EAS torn
• Grade 3c	IAS (internal anal sphincter) also torn
Fourth degree	Disruption of both the anal sphincters and rectal epithelium
Button Hole injury	A vaginal tear that breaches the anal mucosa but does not involve the muscles of the anal sphincters.
Labial injury	Injury to the labia

OASI 2 Care Bundle

The OASI 2 Care Bundle has been developed between the RCOG, the RCM and The Health Foundation to reduce the risk of OASI at vaginal births. All women should be offered the following 4 components of the OASI Care Bundle to reduce their risk of injury:

1. During the antenatal period discuss OASI with women and what can be done to reduce the risk of it occurring in birth.(see [Appendix 1](#))
2. When clinically indicated, episiotomy should be performed mediolaterally at a 60-degree angle (ideally with epi-scissors) at crowning.
3. Documented use of manual perineal protection (MPP) unless declined or birthing in water whilst communicating with the woman to encourage a slow and guided birth. Warm compresses should be offered and used in between contraction.
4. Following birth, the perineum should be systematically examined, and any tears graded appropriately. The examination should include a per rectum examination even if the perineum appears intact.

Potential Risk Factors for Third and Fourth Degree Tears.

Clinicians need to be aware that although there are known potential risk factors these do not allow the accurate prediction of OASI:

- First vaginal birth (including vaginal birth after caesarean)
- Birth weight greater than 4kg

- Difficult vaginal birth (forceps, ventouse, shoulder dystocia, oxytocin augmentation)
- OP position, large HC, post maturity, compound presentation (Hand delivered alongside head).
- Asian ethnicity
- Previous OASI
- Female genital mutilation (FGM)
- Short stature
- Advancing maternal age

Can Obstetric and Sphincter Injury (OASI) be prevented?

Discussions with the woman should be had throughout the pregnancy of the risks of OASI and the care bundle. Antenatally the OASI care bundle patient information and discussion should occur at booking.

A further supported discussion about the intervention of the OASI care bundle to be undertaken from 32 weeks (see [Appendix 1](#))

To guide discussions, refer to the BRAIN (Benefits, Risks, Alternatives, Intuition, Nothing) acronym. (see [Appendix 2](#))

Advise that woman can access the RCOG tears hub for more information

Link: <https://www.rcog.org.uk/for-the-public/perineal-tears-and-episiotomies-in-childbirth/>

Perineal massage during antenatal period and in second stage of labour

Antenatal perineal massage enables perineal tissue to expand more easily during birth and is associated with a lower risk of severe perineal trauma.

Perineal warm compression during the second stage of labour is shown to reduce the risk of OASIS.

Episiotomy:

- Clinicians should explain to women that the evidence for the protective effect of episiotomy is conflicting.
- Mediolateral episiotomy (60-degree angle away from the midline when the perineum is distended) should be considered in instrumental deliveries as it appears to have a protective effect.
- Analgesia should be optimised; assess the effectiveness of epidural (+/- top up) or the perineum to be infiltrated with local anaesthetic.

Perineal protection:

Manual perineal protection at crowning and controlled delivery of the head can be a protective measure and includes:

1. One hand slowing down the delivery of the head.
2. One hand protecting the perineum.

Communication with the woman as the head is crowning is important to promote her breathing as the baby's head crowns.

Assessment

All women who have had a vaginal delivery are at risk of sustaining OASIS or isolated buttonhole tears. Therefore, they should be offered a systematic assessment vaginal examination with a digital rectal examination following all vaginal births, including women with apparently an intact perineum. Of those women suffering from anal incontinence after childbirth, 50% were found to have an incorrect assessment and an OASI missed.

Timing of assessment:

This should not interfere with mother-infant bonding unless there is bleeding that requires urgent attention. The initial examination should be performed gently and with sensitivity and may be done in the immediate period following birth.

Before assessing for perineal trauma (vaginal and rectal examination), healthcare professional should:

- Explain to the woman what they plan to do and why, with consent obtained from the woman to continue.
- Get confirmation by the woman that analgesia is adequate.
- Ensure good lighting.
- Position the woman so that the genital structures can be seen clearly (lithotomy position is preferred).
- Visual assessment of the trauma, the structures involved, the apex of the injury and assessment of bleeding.
- PR examination to assess whether there has been any damage to anal sphincters.

Seek advice from more experienced staff if there is uncertainty about the nature or extent of the trauma.

Explanation

The woman should receive **detailed information** regarding the extent of trauma / repair and consent gained for perineal repair (see [Appendix 1](#) regarding consenting of third and fourth degree perineal tear repair)

Perineal Repair

Difficult trauma should be repaired by an experienced operator in theatre under regional or general anaesthesia. It may be necessary to insert an indwelling catheter to prevent urinary retention.

First and Second Degree Tear

- 1st degree tears do not need to be sutured if the skin is in alignment and there is no bleeding.
- 2nd degree trauma should be sutured in order to improve healing. If a woman chooses not to be sutured, evidence of information and advice given must be documented.
- Perineal trauma should be repaired using an aseptic technique and the perineum rinsed down with water prior to commencing repair. Gloves therefore must be changed after delivering the baby and performing a PR.

- Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.
- Perineal repair should only be undertaken after effective analgesia is ensured either by infiltration with up to 20 ml of 1% lidocaine or topping up the epidural. If the woman reports inadequate pain relief at any point this should be addressed immediately. *note: 19% women reported a 'lot of pain' during suturing and 12% of women reported suturing as the most painful part of childbirth.*
- Good exposure and lighting is essential to see and identify the structures involved.
- An absorbable synthetic suture material (Vicryl Rapide) should be used to suture the perineum.
- Identify the apex of the tear and use a surgical anchor knot to start 1cm above the apex of the tear.
- The vaginal wall and muscle layer should be repaired using a continuous nonlocked suturing technique and the dead-space deep intramuscularly closed to prevent bleeding and lower the risk of infection.
- If the skin is neatly opposed after suturing the muscle there is no need to suture it. Where the skin does require suturing, this should be undertaken using a continuous subcuticular technique.
- Always finish with a surgical knot, ideally not at the fourchette.
- Good anatomical alignment of the wound should be achieved, and consideration given to the cosmetic result.
- Rectal examination should be carried out after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa.

Rectal non-steroidal anti-inflammatory drugs (e.g. Diclofenac 100 mg) should be offered routinely following perineal repair provided these drugs are not contraindicated. Contraindications include postpartum haemorrhage, preeclampsia, renal disease, asthma, concurrent use of other NSAIDs.

Information should be given to the woman about the extent of the trauma, pain relief, diet, pelvic floor and the importance of good hygiene.

After completion of the repair accurately document on the All Wales Clinical Pathway for Normal Labour / Labour Documentation, with a drawing if needed, the following:

- Consent, extent of the trauma, method of repair, type and number of sutures and swabs used. A second signature is required for the swab/needle count.

Community midwives should visibly assess the perineum for signs of infection and wound breakdown with the woman's consent at each postnatal check-up.

- If any signs of infection are present, antibiotics should be prescribed via the GP and a swab taken. Research shows between 1:10-20 wounds breakdown. The wound will then heal by secondary intention which is a much longer and more painful process.

Management of OASI (3rd and 4th Degree Tears)

Once identified it should be repaired by a doctor with appropriate/ relevant qualification in repairing third and fourth degree tears.

FULL EXTENT OF THE INJURY SHOULD BE EVALUATED BY A CAREFUL VAGINAL AND RECTAL EXAMINATION IN LITHOTOMY POSITION IN THEATRE, UNDER SPINAL OR ADEQUATE LOCAL ANALGESIS AND THE TEAR SHOULD BE CLASSIFIED AS ABOVE

The Speciality Obstetric doctor should inform the Consultant when a woman has sustained a fourth degree tear. The Consultant can then make the decision regarding who should undertake the repair, and advise on the appropriate technique for repair.

USE THE PERINEAL REPAIR PACK, WHICH HAS BEEN SPECIALLY PREPARED FOR THIS PURPOSE AND REPAIR SHEET

Principles of repair of OASI

- General or regional (spinal, epidural, caudal) anaesthesia is necessary.
- The repair should be carried out in the operating theatre where there is access to good lighting.
- An assistant should be available.
- Consider short term indwelling catheter until mobility returns.
- The torn anorectal mucosa should be repaired with sutures using either the continuous or interrupted technique. Whichever technique is used, figure of eight sutures should be avoided during repair of the anal mucosa as they can cause ischaemia.
- Where the torn internal anal sphincter (IAS) can be identified, it is advisable to repair this separately with interrupted or mattress sutures without any attempt to overlap the IAS.
- For repair of a full thickness external anal sphincter (EAS) tear, either an overlapping or an end-to-end (approximation) method can be used with equivalent outcomes.
- For partial thickness (all 3a and some 3b) tears, an end-to-end technique should be used.
- When obstetric anal sphincter repairs are being performed, the burying of surgical knots beneath the superficial perineal muscles is recommended to minimise the risk of knot and suture migration to the skin.
- If a suture is identified (inadvertently inserted through the anorectal mucosa), this should be removed.

A rectovaginal examination should be performed to confirm complete repair and to ensure that all tampons or swabs have been removed. All swabs needles and instruments must be counted pre and post repair by two clinicians and this must be recorded on the 3rd/4th Degree tear Proforma. The insertion of any vaginal pack must be clearly recorded on the Proforma.

Third and fourth degree tear repair documentation in the labour birth record **MUST** be completed by the doctor undertaking repair.

- Intra-operative broad-spectrum antibiotic should be used, for all women, to avoid infection. Suggested regime: IV Cefuroxime 1.5g and metronidazole 500mg.
- Prescription of laxatives following perineal repair has shown to reduce the risk of wound dehiscence
- Datix to be completed and number recorded in the birth register.

Choice of suture materials

- 3-0 polyglactin should be used to repair the anorectal mucosa as it may cause less irritation and discomfort than polydioxanone (PDS) sutures.
- When repair of the EAS and/or IAS muscle is being performed, either monofilament sutures such as 3-0 PDS or modern braided sutures such as 2-0 polyglactin can be used with equivalent outcomes.

Documentation

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals. This is a requirement as set by professional colleges including the NMC and RCOG. All entries must have the date and time together with signature and printed name.

Ensure adequate documentation by using the perineal repair page in the Labour /Birth Record Documentation should include:

- The extent of trauma (including a visual image where possible)
- Analgesia used for repair
- Material used
- Technique used
- Swab and needle count prior to and on completion of procedure
- Documentation of advice given.

Follow Up Care

- Receive written information on third and fourth degree tears (RCOG and Physiotherapy)
- Refer for an outpatient gynaecology follow up appointment and debrief from 6 weeks postpartum. Appointments should be made prior to discharge from hospital by emailing the following address and requesting an appointment:
OPDappointments.healthrecordspph@wales.nhs.uk
Once the appointment request has been made this should be clearly documented and explained to the woman
- Referred to the women's health physiotherapy team. Please note there is a minor local variation for each of the sites depending on where the woman lives
Pembrokeshire – Caroline.Mccoy@wales.nhs.uk
Carmarthenshire – physioferral.hdd@wales.nhs.uk
Ceredigion – Leri.physio@wales.nhs.uk

Inform the women that first physio contact may be a telephone consultation.

Subsequent pregnancies

- The risk of sustaining a further third- or fourth-degree tear after a subsequent delivery is 5–7%
- Women identified in subsequent pregnancies should receive Information for women identified in pregnancy as having had a previous third or fourth degree tear ([Appendix 1](#)).
- Assessment should be made of any urinary or bowel symptoms that may contraindicate a vaginal birth i.e. Women who are symptomatic or have abnormal endoanal ultrasonography and/or manometry.
- All women who have sustained OASIS in a previous pregnancy and who are symptomatic should be counselled regarding the option of elective caesarean birth.
- If the woman is symptomatic, an elective caesarean section should be considered.
- A previous third degree tear is not a contraindication to birth in the midwife led unit or at home.
- Women should be aware of the possibility of reoccurrence and that if there is a reoccurrence transfer to the obstetric unit would be required for repair.

Auditable Standards

- Compliance with completion of 3rd/4th Degree Tear Proforma in labour birth record
- Datix Incident Reporting of all 3rd/ 4th Degree Perineal tears in line with the Health Board Maternity Trigger list
- Compliance with follow up physio and gynae referral and appointments.

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Appendix 1: OASI Patient Information



Perineal Health in Pregnancy, Birth & Beyond

Antenatal discussion guide

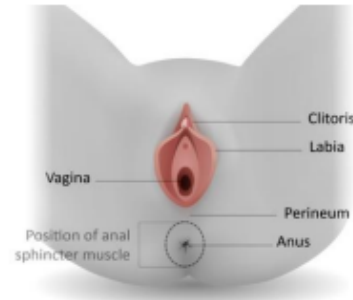
OASI TWO
CARE BUNDLE

V5 AUGUST 2023

What types of perineal tears can occur during childbirth?

During vaginal birth, it is very common to experience a graze or tear of the labia or, more frequently, the **perineum**, which is the **area between your vagina and anus**. For most, these tears are minor and heal quickly.

- **1st and 2nd degree:** tears that involve muscle/skin that may require stitches
- **3rd and 4th degree:** severe tears which extend to the muscles that control the anus (the anal sphincter), requiring stitches. **These are also called 'Obstetric Anal Sphincter Injuries' (OASI).**



Am I at risk of a severe tear?

Severe tears (OASI) occur in **3-4 in 100 births**. You are at significantly higher risk if:

- Forceps are used to help you give birth
- This is your first vaginal birth

The following may also increase your risk:

- You sustained a previous OASI
- Your baby is born in the back-to-back position
- Your baby is over 4kg (9 lbs)
- You are of South Asian ethnicity
- Your baby is born quickly
- You are over 35 years of age
- Your baby's shoulder gets stuck behind the pubic bone (shoulder dystocia)
- Ventouse is used to help you give birth
- The pushing phase of labour takes a long time

The alternative to a vaginal birth is a caesarean birth. Caesarean birth has different risks to yourself, your baby and your future pregnancies.

What about recovery?

Most women and birthing people who have a severe tear (OASI) repaired recover well, although it can take some time. Occasionally, long-term pain and a difficulty or inability to fully control the bladder, bowels or the passing of wind can occur. This could lead to:

- Feelings of depression, low mood, isolation
- Anxiety about leaving the house and not being able to quickly access a toilet
- Difficulty bonding with your baby
- Concerns about leakage while exercising
- Concerns about having sex or giving birth again

If you experience any of the above after birth, contact your doctor or midwife as soon as possible to access specialist care.

BRAIN can help you ask questions

The BRAIN acronym helps you have conversations that will support you to make a decision.

- B** = what are the benefits?
- R** = what are the risks?
- A** = what are the alternatives?
- I** = what does your intuition tell you?
- N** = what happens if we do nothing for now?



How can I reduce my risk of a severe tear?

Perineal massage with a natural oil (such as coconut or almond) from 35 weeks pregnant until birth, as illustrated here. Visit rcog.org.uk/tears for more information on how to do this.



A warm compress is a flannel heated with warm tap water and held against your perineum during the pushing phase of labour. Ask your midwife or doctor if they can provide this.

Spontaneous vaginal birth (*birth without forceps or ventouse*) can be encouraged by choosing the ideal place of birth (consider a homebirth or midwifery-led unit if you are low-risk), avoiding induction and epidural where possible, creating a relaxing environment (consider soothing lighting, sounds, smells) and remaining active throughout labour and birth. *For first-time mothers with an epidural*, lying on your side during the pushing phase of labour is recommended.

Choose a birth position that is most comfortable for you. Listen to your midwife and they will advise a slow and guided birth of the head. Positions at the moment of birth that may reduce risk of severe tears include:



The **OASI Care Bundle** is the following set of practices, most effective when applied together:

- 1 In the antenatal period, your midwife or doctor will **discuss severe tears (OASI) with you** and what can be done to reduce the risk of this occurring.
- 2 With your consent, your midwife or doctor will **use their hands to support** your perineum and the baby's head and shoulders during birth and encourage a slow and guided birth.
- 3 You may need an **episiotomy**—a cut through the vaginal wall and perineum to make more space for your baby to come out—your midwife or doctor will ask for your consent to do this.
- 4 After your baby has been born, your midwife or doctor will ask for your consent to **examine your vagina, perineum and anus** (just inside the back passage) to ensure any tears are identified and appropriately treated to avoid further consequences.

✓ Developed by experts

✓ Supported by women

✓ Found effective in a 2017-18 study (OAS11)

Please speak to your midwife or doctor if you have any questions.
For more information and support, visit: rcog.org.uk/tears or masic.org.uk



Appendix 2. B.R.A.I.N


What is B.R.A.I.N?

The BRAIN's mnemonic (memory aid) is shared with women and is a simple way of collecting and organising information to make informed decisions about their care.

These can be decisions made prior to birth for example when creating birth preferences or in labour when considering consenting to a care procedure. BRAIN can be used as a formal tool with paper or as a simple checklist to make sure the women can have explored all of their options and have the full picture.

B.R.A.I.N

<p>B - Benefits</p> <p>What are the benefits of having this procedure/intervention?</p> <p>R - Risks</p> <p>What are the risks of this process for me, my baby and how will it affect my labour and birth?</p> <p>A - Alternatives</p> <p>What are the alternatives to this procedure - can it be carried out differently or can a different process be used?</p>	<p>I - Instinct</p> <p>What do you feel is right for you, what feels safest, what's your gut instinct?</p> <p>N - Nothing</p> <p>What happens if I do nothing, I'm not ready to decide yet? I don't want to do anything right now/I need time.</p>
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Appendix 3. Consent for Repair of Third and Fourth Degree Perineal Tear

I have explained the procedure for repair of 3 rd or 4 th degree perineal tear to the patient. In particular I have explained:		
Serious Risks	Frequent risks: Common	Frequent risks: Uncommon
<ul style="list-style-type: none"> ▪ Incontinence of stools and/or flatus (common-1/10 to 1/100) ▪ Delivery by caesarean birth in future birth may be recommended if symptoms of incontinence persist or investigations suggest abnormal anal sphincter structure or function(uncommon-1/100-1/1000), ▪ Haematoma (rare-1/1000 to 1/10,000) ▪ Secondary repair or sacral nerve stimulation (rare-1/1000-1/10,000) ▪ Rectovaginal fistula (very rare- less than 1/10,000) 	<ul style="list-style-type: none"> ▪ Faecal urgency 26/100 ▪ Perineal pain and dyspareunia (9/100) ▪ Wound infection (8/100). 	<ul style="list-style-type: none"> ▪ Urinary infection ▪ Granulation tissue formation ▪ Migration of suture material requiring removal ▪ Fear ▪ Difficulty and discomfort in passing stools in the immediate postnatal period.
Extra procedures that may be necessary in the immediate postnatal period:		
Blood transfusion: Accept Decline	Vaginal pack: Accept Decline	

V1 Jan 2026.