MANAGEMENT OF PERINEAL TRAUMA

Approximately 75% of women post vaginal birth will have some degree of trauma to their labia, vaginal walls or perineum. The inadequate diagnosis and inappropriate management of the trauma is strongly associated with increased bleeding, infection, pain, urinary and faecal incontinence and sexual dysfunction. Perineal trauma caused by either tearing or episiotomy should be defined as follows:

1. First degree- injury to skin ONLY
2. Second degree – injury to the perineal muscle but not the anal sphincter.
3. Third degree – injury to the perineum involving the anal sphincter. Further classification –
   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
4. Fourth degree- injury to the perineum involving the internal and external anal sphincters and the anal epithelium.

Assessment of the Perineum Following the Third Stage of Labour:

- Gain consent and discuss the need to assess and determine the extent of any perineal, vaginal or labial trauma once the third stage of labour has been completed.
- The timing of this systematic assessment should not interfere with mother-infant bonding unless the woman has bleeding that needs urgent attention.
- If labour and birth occurred in water and there is no evidence of a moderate to heavy blood loss from the perineal region, wait for at least one hour after the mother leaves the water to allow any tissue engorgement to settle before assessing the perineum.
- Review the perineal status with the woman lying in a recumbent position where visualisation of the perineum and vaginal area is not inhibited, and ensure adequate lighting.
- Place fingers gently inside the vagina and assess the tissue systematically from the clitoral area around to the posterior vaginal wall.
- Expose all vaginal tissue between the rugae to reveal any deep tears. Ensure the apex of the perineal muscle is visible.
• If any trauma to the perineal muscle layers is identified, assessment of the rectal sphincter should be carried out to exclude involvement, before attempting repair. 

• Anal assessment includes:
  
  o Further consent and discussion of the examination explained to the woman.

  o Observe the anus for the absence of “puckering” (especially at the positions of 10 & 2) which may be suggestive of anal sphincter injury.

  o Visualising the muscle from the perineal tear, insert a finger into the rectum and ask the woman to squeeze.

  o The bulk of the sphincter should also be able to be palpated intact between the thumb and the finger.

  o If there is any involvement with the external anal sphincter confirmed or suspected, immediate referral and consultation with the support hospital must occur.

• Discuss the recommendation to suture all tears where:

  1. The tissue and/or muscle layer is not approximated due to the contractile nature of the tissue.

  2. Ragged tissue is inhibiting alignment of skin margins.

**Recommended Techniques for Perineal Repair (by a midwife qualified in perineal repair)**

  1. Where the perineal skin margins are well defined consider performing a two layer repair.

  2. Where perineal skin margins are ragged consider a three layer repair to align the skin margins.

  3. Vicryl Rapid 3/0 is recommended for repair of the delicate tissue in the labial region.

  4. Vicryl Rapid 2/0 is recommended for all tissue and muscle repair associated with the posterior vaginal wall and the perineal body.

  5. Document the technique used to complete the repair using CMP MR08, page 23.

**Referral for Obstetric Review Shall Occur when:**

  1. There is trauma involving the anal sphincter (3rd degree tear).

  2. Where an ano-vaginal fistula has occurred, confirmed by doing a rectal examination (4th degree tear).
3. Any trauma that is more extensive than you are competent to repair (including clitoral and urethral) irrespective of the degree of trauma. Consult with the support midwife prior to transfer if necessary.

4. Excessive bleeding from genital tract trauma requiring further investigation. Apply pressure to the area and transfer immediately to support hospital. See CMP Guideline for Postpartum Haemorrhage (PPH).

**Management of Perineal Trauma Requiring Obstetric Review:**

- Document assessment and recommendations in CMP MR08.
- Complete a full set of maternal observations and document all findings.
- Discuss the management recommendations with the mother and primary support person.
- Contact the support hospital and obstetrician to inform them of the transfer.
- Transfer by ambulance must occur if the woman is haemodynamically unstable or actively bleeding from the tear. Consider inserting a cannula and commencing fluids (following a verbal order) prior to transfer in this situation.
- Accompany the woman and take all her notes to the hospital.
- Ensure that the primary support person and baby accompany mother.
- Postnatal management of perineum as detailed in CMP guideline Maternal Observations.
REFERENCES / STANDARDS


National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice
   2- Provision of Care

Related Guidelines / Policies – KEMH Episiotomy / Genital Laceration: Suturing
KEMH Perineal Trauma: Third and Fourth Degree Management

Other related documents – Midwifery care when a Client Makes a Decision that Is Incompatible with the CMP Midwifery Standard of Practice
Transfer Home to Hospital

RESPONSIBILITY
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Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.

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