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 third & fourth degree tears

3. STAFF

- Medical and midwifery staff accredited to perform perineal repair

4. EQUIPMENT

- Light source
- Leg supports
- Suture pack
- Sterile drapes
- Abdominal sponges 20x20cm radio-opaque
- Vaginal plug (tampons) with tails radio-opaque
- 23 gauge needle, 20ml 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

- Consent woman for systematic genital tract examination following a vaginal birth immediately after delivery of placenta including a rectal examination
- Explain repair procedure fully to the woman and gain verbal consent
- Identify any known allergies to local anaesthetic or antiseptic
- Assist the woman into lithotomy to increase clear visualisation of the genital tract trauma/tear

Assessing the Tear

- Assess the genital tract in good light to visualise the apex of the wound and determine the presence of other trauma such as obstetric anal sphincter injuries (OASIS) that may require further consultation +/- suturing
- Assess extension of trauma with second experienced practitioner to confirm the diagnosis and grading[11]
- Discuss findings of perineal examination with the woman, explaining the rationale for the perineal repair
- Determine confidence to proceed with repair, or if more experienced staff or alternate location required, such as operating theatre for repair of a complex, third degree or fourth degree tear

Repairing the Tear

- Advise repair under aseptic technique as soon as possible after birth to reduce risk of bleeding and infection
- Prepare equipment on designated suture or other cleaned trolley
- Perform correct handwashing, don PPE – including double gloves
- Perform verbal count of equipment with assistant and document on Maternity: Record of Labour – Genital Tract Trauma Repair (GTTR) form

PERINEAL/GENITAL TRACT REPAIR cont'd

- Perform time out to confirm patient, consent and procedure
- Cleanse perineal area using chlorhexidine 0.2%
- Drape the woman and maintain privacy
- Infiltrate the perineal area with local anaesthetic as required:
    - Lignocaine 1% without adrenaline maximum dose of 20mls (200mg over an hour)
    - Ensure effectiveness of analgesia before commencing suturing
- Repair the perineal wound in three layers (vaginal wall, perineal muscle, perineal skin) using a rapidly absorbed suture such as 2-0 Vicryl Rapide
- Commence suturing from approximately 0.5cm above the apex to introitus using continuous non-locking suturing technique
- Continue to suture until the hymenal remnants are reached approximating wound edges and eliminating dead space
- Ensure perineal muscle is apposed in one or two layers depending on the depth of trauma. Interrupted or continuous sutures may be used
- Eliminate dead space as much as possible to reduce risk of infection and wound breakdown
- Appose perineal skin edges with sub-cuticular suture starting from the inferior end of the wound
- Inspect the vagina, after obtaining consent
- Perform rectal examination, with consent, to check no suture maternial has perforated the rectum, escalate to senior obstetric doctor if this has occurred
- Explain perineal hygiene and expected health process to the woman
- Check fundus and blood loss
- Perform count of instruments, sponges, vaginal plugs, sharps with second staff member and document on Maternity: Record of Labour – Genital Tract Trauma Repair (GTTR) form
- Dispose of sharps appropriately
- Ensure the woman is in a comfortable clean bed and adequate postnatal analgesia is prescribed
- Offer woman analgesia (oral or rectal)

6. DOCUMENTATION

- Medical record
- Maternity: Record of Labour – Genital Tract Trauma Repair (GTTR) form

7. EDUCATIONAL NOTES

- Perineal tears are a common outcome of vaginal births[2]
- More than 85% of females how undergo a vaginal birth will suffer from some degree of perineal tear[1]
- 0.6 – 11% of all vaginal deliveries result in third or fourth degree tears[2]
- The incidence of perineal tears decreases with subsequent births, from 90.4% in women who are nulliparous to 68.8% in women who are multiparous undergoing vaginal deliveries[2]
- There are limited studies comparing non suturing first and second degree tears with suturing and these studies only looked at short term outcomes. 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[6]
- Continuous non-locking suturing is considered best practice for all layers[3]. It may be possible to repair perineal mucosa, perineal muscle and perineal skin edges with the same continuous suture

PERINEAL/GENITAL TRACT REPAIR cont'd

- Perineal skin apposition with continuous subcuticular sutures is considered best practice, however interrupted sutures can be used at clinicians discretion, this may impact on the woman's comfort levels postnatally[3,6]
- There is limited evidence from the use of local cooling with ice or cool packs to prevent pain, however it may help with the reduction of swelling and therefore discomfort[8]
- Rectal analgesia is associated with less pain in the 24hours after childbirth and less need for additional analgesia and non-steroidal anti-inflammatory drugs (NSAIDS) should be considered of not contra-indicated or cautioned e.g. pre-eclampsia, asthma

Classification of Perineal Tears[11]:

1st Degree – Injury to perineal skin and/or vaginal mucosa
2nd Degree – Injury to perineum involving perineal muscle but not the anal sphincter
3rd Degree – Injury to perineum involving the anal sphincter complex, which are further subdivided into 3A, 3B, 3C
- 3A - <50% of the external anal sphincter (EAS) torn
- 3B - >50% of the EAS torn
- 3C – EAS and internal anal sphincter (IAS) torn

4th Degree – injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa

Risk Factors for Perineal Tears[1]

Table 1

Maternal Risk Factors	Fetal Risk Factors	Intrapartum Risk Factors
Nulliparity	Large fetal weight (>4kg)	Instrumental Delivery
Asian ethnicity	Shoulder Dystocia	Prolonged second stage
Vaginal birth after caesarean section	Occipito-posterior position	Epidural use
≤20 years of age		Oxytocin use
Shortened perineal length (<25mm)		Midline episiotomy
		Delivery in lithotomy or deep squatting position

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Second stage of Labour – 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 theatres)
- Vaginal examination in Labour
- Assisted vaginal birth guideline – SESLHDGL/050
- Postpartum haemorrhage – prevention and management

9. RISK RATING

- Low

10. NATIONAL STANDARD

- Comprehensive Care – standard 5
- Preventing and Controlling Health Care Associated Infections – standard 3

PERINEAL/GENITAL TRACT REPAIR cont'd

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REVISION & APPROVAL HISTORY

Reviewed and endorsed Maternity Services LOPs 2/6/20
Approved Quality & Patient Safety Committee 16/7/15
Reviewed and endorsed Maternity Services LOPs July 2015
Approved Quality & Patient Safety Committee 19/9/13
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 2025