

# Perineal care

Clinical Guideline Presentation v3.0



**45 minutes**

Towards CPD Hours

**References:**

Queensland Clinical Guideline: Perineal care is the primary reference for this package.

**Recommended citation:**

Queensland Clinical Guidelines. Perineal care clinical guideline education presentation E18.30-1-V3-R23. Queensland Health. 2018.

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# Learning objectives

- Define standard perineal tear classification
- Identify risk factors for OASIS
- Outline care principles for identifying and caring for women who have experienced FGM
- Identify antenatal and intrapartum measures to reduce risk of perineal trauma
- Outline postnatal perineal assessment and repair
- Outline postnatal care and management of the perineum
- Aid women with history of OASIS in decision making

# Standard perineal tear classification

Tear	Definition	
<b>First degree</b>	Injury to the skin or vaginal epithelium only	
<b>Second degree</b>	Injury to the perineum involving perineal muscles but not involving the anal sphincter	
<b>Third degree</b>	Injury to perineum involving the anal sphincter complex <ul style="list-style-type: none"> <li>• 3a: Less than 50% of external anal sphincter (EAS) thickness torn</li> <li>• 3b: More than 50% of EAS thickness torn</li> <li>• 3c: Both EAS and internal anal sphincter (IAS) torn</li> </ul>	Third and fourth degree tears are collectively known as <b>OASIS</b>
<b>Fourth degree</b>	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium	
<b>Rectal buttonhole</b>	<ul style="list-style-type: none"> <li>• Injury to rectal mucosa with an intact anal sphincter</li> <li>• Not a fourth degree tear</li> </ul>	

# OASIS

- Rates of OASIS are increasing in Australia and in comparable countries
- Increasing rates may be due to rising incidence, improved detection or both
- OASIS can result in long term sequelae such as faecal incontinence, and can significantly affect a woman's quality of life

# OASIS risk factors

The vast majority of OASIS occur in women who are categorised as low risk

## **Risk factors include:**

- Asian ethnicity
- First vaginal birth
- Birth weight greater than 4kg
- Shoulder dystocia
- Instrumental birth
- Occipito-posterior position
- Prolonged second stage
- Midline episiotomy

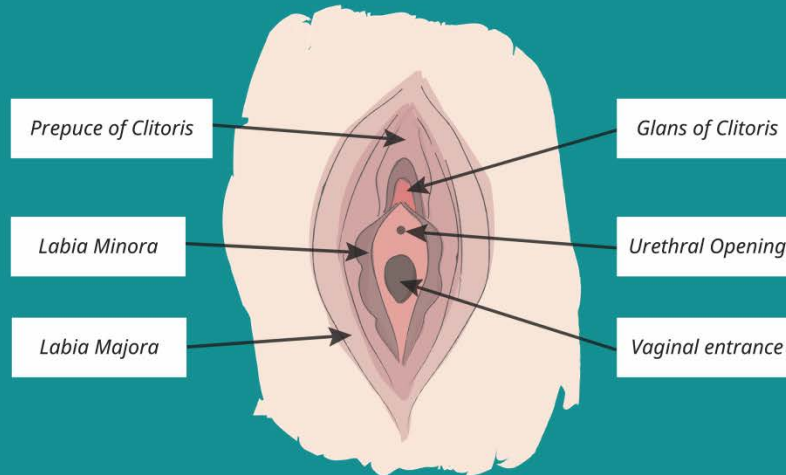
# Female Genital Mutilation (FGM)

FGM is an umbrella term for procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.

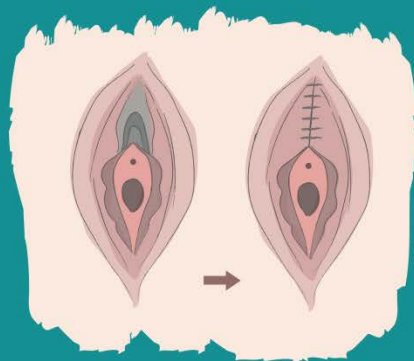
## FGM classification

Type	Classification
I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
IV	All other harmful procedures to the female genitalia for non-medical purposes (e.g. pricking, piercing, incising, scraping and cauterising)

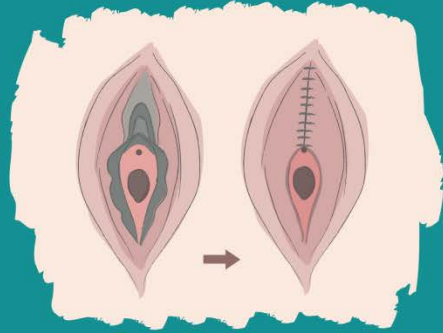
# Classification of Female Genital Mutilation / Cutting



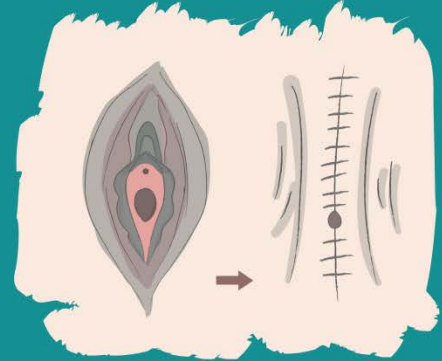
Normal



Type I



Type II



Type III



# FGM

Belinda is 14 weeks pregnant, and presents to the maternity outpatients department for a booking in appointment.

## What principles can help guide you in a discussion about FGM with Belinda?

- Ask all women for a history of FGM at booking
- The term “mutilation” may not be appropriate to women who have experienced FGM. Consider terminology such as “cutting” or “circumcision” instead
- If FGM identified, refer to a clinician experienced and trained in the management of women with FGM
- Inspect vulva to determine classification of FGM and to determine whether deinfibulation is indicated



# Antenatal risk reduction

Belinda is now 30 weeks pregnant attending a routine appointment.

## What can you tell Belinda about how she can reduce her risk of OASIS?

- Antenatal perineal massage (APM): may reduce risk of episiotomy and of trauma requiring suturing
- Pelvic floor muscle training (PFMT): may shorten first and second stage of labour
- Combining APM and PFMT from 32 weeks may reduce risk of episiotomy, OASIS and postpartum perineal pain



# Intrapartum risk reduction

You and Belinda are discussing her preferences for birth.

**What can you tell Belinda about the risks and benefits of various positions for birth?**

- Greatest incidence of intact perineum in all-fours and kneeling positions
- Lowest incidence of OASIS in standing and lateral positions
- Greatest incidence and degree of trauma in sitting, squatting and birth-stool positions
- Increased risk of OASIS associated with lithotomy and squatting positions



# Intrapartum risk reduction

Belinda presents in spontaneous labour at term and progresses to second stage. She is actively pushing and there is head on view.

## How can you help reduce the risk of perineal trauma when caring for Belinda in second stage?

- Offer in second stage:
  - Intrapartum perineal massage (IPM)
  - Warm perineal compresses
- Both IPM and warm compresses may reduce risk of OASIS
- Aim to slow birth of head at time of crowning by communicating clearly and discouraging active pushing at time of crowning

# Intrapartum risk reduction

Belinda progresses to second stage. She is actively pushing and there is head on view.

## What techniques are recommended to support the fetal head and perineum during second stage?

- High level evidence does not demonstrate any clear differences between hands on and hands off (or poised) for risk of OASIS
- Episiotomy rates are higher with hands on technique
- Recommended to:
  - Have hands on or poised over the fetal head whenever possible
  - Use clinical judgement in determining whether to have hands on or off the perineum

# Intrapartum risk reduction

Towards the end of second stage, there is a large amount of head on view, but the baby has a prolonged bradycardia. In order to expedite the birth, an episiotomy is cut.

## What does the evidence tell us about episiotomy?

- Restrictive (not routine) episiotomy is recommended
  - Performed selectively by indication
  - 30% less incidence of severe trauma than routine episiotomy
- Mediolateral episiotomy is recommended
  - Angle of incision from midline: ideally cut at 60 degrees, no less than 45 degrees
- Ensure effective analgesia
- Perform at crowning of fetal head

# Perineal assessment

Belinda progresses to a vaginal birth of a healthy baby boy.



**What is required for a thorough assessment of the perineum?**

- Adequate analgesia
- May be done immediately after birth
- Good lighting and maternal position to allow clear view
- Visual examination
- Vaginal examination
- If trauma detected during vaginal examination, rectal examination also recommended
- Double check assessment with senior clinician if unsure or inexperienced

# Perineal assessment

<b>Visual exam</b>	<ul style="list-style-type: none"><li>• Check peri-urethral area, labia, proximal vaginal walls</li><li>• Check if tear extends to anal margin or AS complex</li><li>• Check for absence of anterior anal puckering</li></ul>
<b>Vaginal exam</b>	<ul style="list-style-type: none"><li>• Check cervix, vaginal vault, side walls, floor &amp; posterior perineum</li><li>• Identify apex of injury</li></ul>
<b>Rectal exam</b>	<ul style="list-style-type: none"><li>• Check if separated ends of a torn external AS retract backwards</li><li>• Check if inconsistencies in AS muscle bulk</li><li>• Check integrity of anterior rectal wall</li></ul>



# Perineal repair

Belinda's assessment reveals that the episiotomy has not extended.

## What principles should be followed for repair of Belinda's perineum?

- No high level evidence on optimal timing for repair
- Recommend repair undertaken as soon as practicable following birth, as women can find lengthy delays distressing
- Minimise interference with mother-baby bonding as much as possible
- Ensure adequate analgesia
- Ensure good lighting and maternal position to optimise clear view of perineum

# Perineal repair

## What principles should guide the suturing of Belinda's episiotomy?

- Suturing is recommended for second degree tears
- Use an absorbable synthetic suture material
- Use continuous, non-locked suturing
- If skin is apposed after suturing the muscle layer, and there is evidence of haemostasis, the skin can be left unsutured
- If suturing of skin is required, repair with continuous, non-locked subcuticular sutures using non-locked, synthetic suture material. Surgical glue can also be used.



# Perineal assessment

Anya has just given birth to her first baby. Forceps were used to assist the birth, and the baby weighs 4.5kg. Anya had an episiotomy cut prior to the forceps being applied. You are assessing her perineum for trauma and are concerned she may have a 3<sup>rd</sup> degree tear

## What would alert you to a possible OASIS?

- Anya has several risk factors for OASIS (first baby, use of forceps, birth weight of 4.5 kg)
- Signs of possible OASIS include:
  - Episiotomy visually extending to anal margin or anal sphincter complex
  - Absence of puckering around anus
  - Vaginal examination revealing torn sphincter
  - Rectal examination demonstrating gap/inconsistency in sphincter



**If in any doubt, refer to more experienced clinician!**

# Perineal assessment

Unfortunately, thorough assessment has shown that Anya has a 3B tear

## What principles guide the repair of OASIS?

- Generally performed in OT
- Repair by competent operator
- Ensure adequate anaesthesia
- Avoid figure of eight sutures
- Consider antibiotics at time of repair
- EAS repair
  - Use monofilament such as 3-0 polydioxanone or modern braided sutures such as 2-0 polyglactin
  - For full thickness EAS tear, use overlapping or end-to-end
  - For partial thickness, use end-to-end
- To avoid suture migration, trim suture ends and bury in deep and superficial perineal muscles
- Consider IDC post operatively as increased risk of urinary retention postpartum

# Postpartum care

Anya's 3B tear has been repaired and she is now recovering in the postnatal ward

## What postpartum care is recommended for Anya?

- Pain relief
  - If not contraindicated, paracetamol and NSAIDs are first line analgesics  
Minimise use of narcotics and encourage water intake to avoid constipation
  - Cold packs for 10 to 20 minute intervals for 24 to 72 hours
- Bowel care
  - Use stool softeners for 10 days after repair
  - Aim for soft formed motions to minimise pain on defecation, avoid constipation and disruption of repair
  - Encourage fluid intake of 2 to 2.5 L per day, intake of fibre and mobility
- Referral to physiotherapist and continence nurse where available
- Obstetric review appointment 6 to 12 weeks post partum

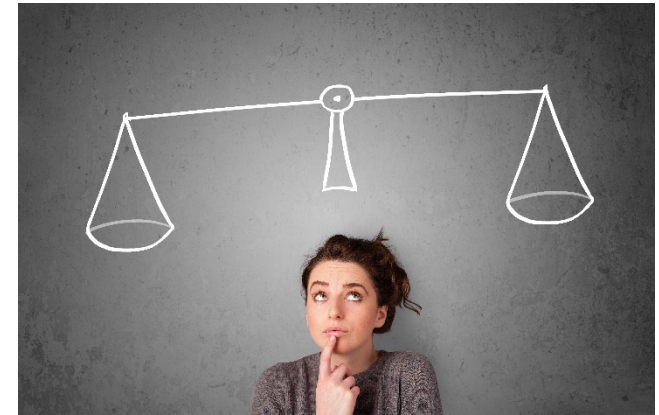
# Postpartum care

## What advice can you give Anya about caring for her perineum?

- Use positions that reduce perineal oedema, especially in first 48 hours (e.g. promote side lying)
- Avoid activities that increase intra-abdominal pressure (e.g. sit ups)
- Commence pelvic floor muscle exercises
- Emphasise importance of good hygiene and avoiding constipation
- Educate regarding monitoring of wound at least daily for signs of wound breakdown and infection
- Discuss return to sexual activity
- Advise to report any signs of infection, wound breakdown, dyspareunia or incontinence to health care provider

# Previous OASIS and decision making

Two years later, Anya is pregnant again and presents to the hospital for antenatal care.



**How can you help Anya decide on the mode of birth for her next birth?**

- Reported OASIS recurrence rates are estimated around 4% to 8%
- Risk factors for recurrence include: instrumental birth; birth weight > 4 kg; previous fourth degree tear
- Factors to consider include: extent of previous injury; functional status; extent of defects shown on anal USS and anal manometry
- Indications to offer CS include: current symptoms of anal incontinence; psychological/sexual dysfunction; endoanal defects on USS, previous fourth degree tear; low anorectal manometric pressures, woman's request