Perineal care
Clinical Guideline Presentation v2

45 minutes
Towards your CPD Hours
References:
The Queensland Clinical Guideline *Perineal care* is the primary reference for this package.

Recommended citation:

Disclaimer:
This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

Feedback and contact details:

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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AS</td>
<td>Anal sphincter</td>
</tr>
<tr>
<td>ASI</td>
<td>Anal sphincter injury</td>
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<tr>
<td>BP</td>
<td>Blood pressure</td>
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<tr>
<td>CT</td>
<td>Computerised tomography</td>
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<tr>
<td>EAS</td>
<td>External anal sphincter</td>
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<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<tr>
<td>IAP</td>
<td>Intra-abdominal pressure</td>
</tr>
<tr>
<td>IAS</td>
<td>Internal anal sphincter</td>
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<tr>
<td>IDC</td>
<td>Indwelling catheter</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<tr>
<td>NSAID</td>
<td>Non-steroidal anti-inflammatory</td>
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<tr>
<td></td>
<td>drugs</td>
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<tr>
<td>OT</td>
<td>Operating theatre</td>
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<tr>
<td>PFME</td>
<td>Pelvic floor muscle exercises</td>
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<tr>
<td>PPH</td>
<td>Postpartum haemorrhage</td>
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<tr>
<td>PR</td>
<td>Per rectum</td>
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<tr>
<td>RR</td>
<td>Respiratory rate</td>
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<tr>
<td>SpO2</td>
<td>Pulse oximetry</td>
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### Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Crowning</td>
<td>When the biparietal diameter of the fetal head passes through the pelvic outlet</td>
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<tr>
<td>Deinfibulation</td>
<td>A surgical procedure to reverse infibulation</td>
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<tr>
<td>Dyspareunia</td>
<td>Pain on vaginal penetration &amp;/or during intercourse or orgasm</td>
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<tr>
<td>Hands-on</td>
<td>The accoucheur’s hands apply manoeuvrers to flex the fetal head, protect the perineum &amp; birth the fetal shoulders</td>
</tr>
<tr>
<td>Hands-off</td>
<td>The accoucheur’s hands are poised to apply pressure to the fetal head only if there is rapid head expulsion, otherwise, they do not touch the perineum or fetal head &amp; shoulders</td>
</tr>
<tr>
<td>Infibulation</td>
<td>FGM that involves excision/stitching of the external genitalia &amp; vaginal opening</td>
</tr>
<tr>
<td>PFME</td>
<td>Exercises to strengthen abdomino-pelvic &amp; pelvic floor muscles</td>
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<tr>
<td>Perineum</td>
<td>Extends from the pubic arch to the coccyx &amp; includes the anterior urogenital triangle &amp; posterior anal triangle</td>
</tr>
<tr>
<td>Perineal injury</td>
<td>Refers to perineal soft tissue damage, tearing &amp; episiotomy</td>
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<tr>
<td>Reinfibulation</td>
<td>A procedure that reinstates infibulation</td>
</tr>
<tr>
<td>Restricted episiotomy</td>
<td>Where the episiotomy procedure is not used routinely but only for specific clinical conditions (e.g. fetal compromise &amp; selected use in instrumental deliveries)</td>
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<tr>
<td>Slow birth of the fetal head</td>
<td>Measures to prevent rapid head expulsion at the time of crowning e.g. counterpressure to the fetal head or minimisation of active pushing, but does not include flexion or other such manoeuvres</td>
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Objectives

• Define types of perineal tears
• Outline maternal counselling & staff training
• Identify risk factors for anal sphincter injury
• Identify risk reduction measures
  ◦ Including consideration of deinfibulation
• Outline assessment, diagnosis & care of puerperal haematoma
• Outline postnatal perineal assessment & repair
• Outline aspects of postnatal perineal care
• Identify advice for follow-up & subsequent pregnancies
## Perineal outcomes

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
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<tr>
<td>Intact</td>
<td>No tissue separation at any site</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; degree tear</td>
<td>Injury to the skin only</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; degree tear</td>
<td>Injury to the perineum involving perineal muscles but not involving the AS</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; degree tear</td>
<td>Injury to perineum involving AS complex: 3a: Less than 50% of EAS thickness torn 3b: More than 50% of EAS thickness torn 3c: Both IAS &amp; EAS torn</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; degree tear</td>
<td>Injury to perineum involving AS complex (IAS &amp; EAS) &amp; anal epithelium/rectal mucosa</td>
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Clinical standards: counselling

• Antenatally, discuss individual risk of perineal injury
• If FGM, seek advice or refer to expert services
• Provide information before & support during perineal procedures
• Provide written & verbal information about injury, repair & follow-up
• Offer clinical or open disclosure, as needed
• Use accredited interpreters
• Document counselling outcomes
Clinical standards: training

Include:
• Identifying risk factors & risk reduction measures
• Recognition & management of perineal injury
• Case scenarios & repair simulation exercises
• Surgical skills workshops
• Formal medical training for anal sphincter repair
• Physiotherapist training for pelvic floor assessment & rehabilitation
• Processes for competency & recognition of prior learning
Anal sphincter injury risk factors

Risk factor awareness is less about prediction or prevention & more about improving injury detection rates

- Primiparity
- Asian ethnicity
- Infibulation of genitalia
- Previous AS disruption
- Persistent fetal OP position
- Induction & augmentation of labour
- Epidural anaesthesia
- Second stage of labour > 1 hour
- Episiotomy - particularly midline
- Instrumental delivery - particularly forceps
- Shoulder dystocia
- Birth weight > 4 kg
Antenatal risk reduction

Aim: reduce injury, pain &/or pelvic floor dysfunction

• Inform women about:
  ◦ Digital perineal massage
    ▪ Reduces postnatal perineal pain
    ▪ Reduces severity of injury in primigravidae
  ◦ Intensive antenatal PFME
    ▪ Reduces postnatal incontinence
  ◦ Risks/benefits of perineal stretching device
    ▪ Insufficient evidence to promote general use
    ▪ May reduce injury incidence/severity
• If FGM or previous ASI consult with obstetrician
FGM: communication

• Use correct terminology
• Ensure manner is:
  ◦ Kind & culturally sensitive
  ◦ Non-judgemental
• Use accredited interpreters
• Offer social worker services
• Include woman’s preferred support person(s) in discussions
FGM: antenatal care

- Refer as needed (e.g. mental health services, expert FGM services)
- Offer elective late 2nd trimester deinfibulation
- Inform woman of:
  - Intrapartum issues
  - Perineal injury risks
  - Legal restrictions on postnatal reinfibulation
- Document woman’s decisions re deinfibulation & birth plan
FGM: intra & postpartum care

- **Active labour**: Consider IV access & epidural
- **Anterior episiotomy**: Give anaesthetic, catheterise, cut along vulval incision scar, avoid clitoral & urethral meatus injury
- **Posterior episiotomy**: Deinfibulate prior to evaluating for episiotomy
- **Repair**: Control bleeding, appose each side of incision & prevent spontaneous reinfibulation
- **Post birth**: Ensure adequate analgesia, arrange 6 week review
Intrapartum risk reduction

Second stage of labour

Clinical measures:

• Inform women that:
  ◦ Specific positions & pushing techniques are unsupported by current evidence
  ◦ Neither hands-on nor hands-off techniques reduce risk of perineal injury
    ▪ Hands-on reduces ‘mild’ postnatal perineal pain
  ◦ At crowning: slowing birth of the head may reduce risk of perineal injury
Intrapartum risk reduction

Second stage of labour

Perineal techniques:

- Important: go to guideline to review techniques
- Inform women of potential to reduce risk of 3rd/4th degree tears
- Where informed consent provided, apply:
  - Perineal warm packs: use only if normal skin sensation
  - Perineal massage: avoid chlorhexidine based lubricants
Intrapartum risk reduction

Second stage of labour

Interventions:

• Implement restrictive-use episiotomy policy:
  ◦ Use episiotomy when needed (e.g. selected instrumental births, if fetal compromise)
• Cut mediolateral episiotomy with incision at a 45-60° angle away from midline
• Use vacuum extractor over forceps if clinically possible
Assessment & repair principles

Ensure:

- Informed consent
- Adequate analgesia
- Maternal support/comfort during procedure
- Performance/supervision by a skilled practitioner

For repair:

- Timely repair that balances need for uninterrupted skin-to-skin contact
- Pre & post procedural counts of needles/swabs

- Documentation of both procedure & outcomes
Postnatal perineal assessment

Visual exam alone can lead to underestimation of degree of trauma

| Visual exam | • Check periurethral area, labia, proximal vaginal walls  
|            | • Check if tear extends to anal margin or AS complex  
|            | • Check for absence of anterior anal puckering |
| Vaginal exam | • Check cervix, vaginal vault, side walls, floor & posterior perineum  
|            | • Identify apex of injury |
| Rectal exam | • Check if separated ends of a torn external AS retract backwards  
|            | • Check if inconsistencies in AS muscle bulk  
|            | • Check integrity of anterior rectal wall |
Puerperal haematoma

Timely diagnosis can reduce risk of maternal morbidity or death

Presentation:

• Hallmark symptom is:
  ◦ Excessive or persistent pain
  ◦ Location varies with haematoma site

• Other symptoms include:
  ◦ Shock symptoms disproportionate to visible blood loss
  ◦ Pelvic pressure
  ◦ Urinary retention
  ◦ Unexplained pyrexia
Puerperal haematoma

Assessment & diagnosis:

• Listen to the woman
• Inform re need for vaginal &/or rectal exam
• Check for vulval swelling
• Palpate for vaginal, ischiorectal or abdominal masses
  ◦ Abdominal - may cause fundal deviation
• Check for levator trauma
• Consider ultrasound, CT or MRI to diagnose
  ◦ Use contrast-enhanced CT to detect active bleeding
Puerperal haematoma

Treatment:

• **Shock:** Go to Guideline: Primary PPH
  ◦ Transfer to OT after adequate resuscitation

• **Large non-haemostatic haematoma:** Remove clot, repair &/or tamponade vessels (i.e. pack)
  ◦ Consider arterial ligation/embolisation
  ◦ Administer intraoperative antibiotics
  ◦ Drain insertion is discretionary
  ◦ Insert IDC & monitor fluid balance

• **Small static haematoma:** Observe, apply ice

• **Levator trauma:** Refer to physiotherapist/uro-gynaecologist
Puerperal haematoma

Postnatal care:
• Monitor for re-occurrence:
  ◦ Assess pain, pulse, BP & temperature
• Check for & treat coagulopathy or anaemia
• Give analgesia regularly & before removal of pack or drain
  ◦ Remove pack 12-24 hours post insertion
  ◦ Remove drain if loss < 50 mL in 12 hours
• Offer obstetric debriefing prior to discharge
• Encourage GP follow up
Repair of 1st & 2nd degree tears

First degree:
- If haemostatic & apposed, suturing is not required
- If woman’s preference, suture to reduce pain
- Repair using subcutaneous suture or glue

Second degree:
- Discuss suturing versus non-suturing options
- Use:
  - Rapid absorbing synthetic suture (2.0 needle size)
  - Continuous, non-locking technique for all layers
  - Subcutaneous suture or glue for skin
- Check rectum for suture penetration post repair
Repair of 3rd & 4th degree tears

- Utilise theatre, expert operator, regional or general anaesthetic
- Use overlapping or end-to-end technique
- If using long acting/non-absorbable sutures bury knots in superficial perineal muscle
- **IAS**: Repair separately with interrupted sutures & fine needle
- **EAS**: Use polydioxanone or polyglactin
- **Anal epithelium**: Use interrupted sutures (2.0 polyglactin); tie knots in anal lumen
Postpartum pain reduction

• If tear is near urethra consider IDC for 24-48 hours
• Apply ice packs for first 24-72 hours
• Advise gentle perineal compression
• Post 2nd degree/episiotomy repair offer PR NSAID
• Offer early in postnatal period:
  ◦ 1 gram oral Paracetamol
  ◦ Oral NSAID (if PR dose not given)
  ◦ Urinary alkaliser
• Minimise use of narcotics
• Codeine not recommended if breastfeeding
Promoting perineal healing

• For ASI administer:
  ◦ Prophylactic IV antibiotics (e.g. Cephazolin & Metronidazole)
• Prescribe at least 10 days of laxatives
  ◦ Advise to see GP if constipated or faecal incontinence post discharge
• For 4th degree (& complex 3rd degree) tears
  ◦ Continue 24 hours of IV antibiotics
  ◦ Follow with 5 days of oral antibiotics
Positions, movement & exercise

• Teach positions that reduce dependent perineal oedema:
  ◦ Lie bed flat, avoid overuse of sitting positions
• Discuss risk of increased IAP & to avoid for 6-12 weeks:
  ◦ Straining, lifting, high impact exercise, sit-ups
• Teach correct PFME technique & need to continue long term
  ◦ If done incorrectly may disrupt wound healing
• Women with ASI: Refer to physiotherapist before discharge
Hygiene, healing & diet

• Inform woman how to assess wound:
  ◦ Educate re signs of infection & dehiscence
  ◦ Explain when to report to midwife or GP

• Advise to:
  ◦ Support wound when defecating/coughing
  ◦ Keep clean by regular showers/pad changes, wash/dry wound post-toileting, hand hygiene

• Educate re healthy, balanced, high fibre diet
  ◦ Advise 1.5-2 L water daily, especially if taking laxatives or Iron tablets

• Treat anaemia, discuss diet
  ◦ Consider 2 week delay in start of iron therapy
Follow-up

For women with perineal injury:
• Advise woman to see GP/midwife at 6 weeks
  ◦ See GP earlier if signs of infection, wound dehiscence, constipation or faecal/urinary incontinence
• Refer to continence clinic (where available)
• Discuss dyspareunia & when to see GP

Add for women with ASI:
• Arrange 6-12 week obstetric review
  ◦ If AS dysfunction refer to uro/gynaecologist
• Refer to physiotherapist
ASI: post repair advice

• 60-80% of women remain asymptomatic
  ◦ Symptomatic women mostly report faecal urgency or incontinence of flatus
• If symptomatic & abnormal ultrasound/manometry: elective caesarean section is a future birth option
  ◦ If without symptoms: best practice is unknown
• For vaginal birth in subsequent pregnancies:
  ◦ 17-24% chance of worsening symptoms afterwards
  ◦ Risk of repeat ASI is equal to primigravidae
  ◦ Prophylactic episiotomy use is not supported
• Report ASI to subsequent care providers
Guideline appendices

• Pelvic floor muscle exercises
• Female genital mutilation classification & country