

Perineal assessment and repair

General principles for perineal assessment and repair

- Ensure privacy
- Seek consent prior to assessment and repair
- Communicate clearly and sensitively
- Position woman to optimise comfort and clear view of perineum ensuring adequate lighting
- Perform assessment and repair as soon as practicable while minimising interference with mother-baby bonding
- Ensure adequate analgesia throughout assessment and repair
- Ensure clinician competent to perform assessment and repair—refer to more experienced clinician as required

Perform systematic assessment

- Visual assessment
 - Periurethral area, labia, proximal vaginal walls
 - Extent of tear
 - Presence or absence of anterior anal puckering
- Vaginal examination
 - Cervix, vaginal vault, side walls, floor and posterior perineum
 - Note extent of tearing
 - Identify apex
- Rectal examination
 - Insert index finger into rectum and ask woman to squeeze while feeling for any gaps anteriorly
 - If unable to squeeze (e.g. epidural), assess using “pill-rolling motion” checking for inconsistencies in anal sphincter muscle
 - Check integrity of anterior anal wall
 - Note detection of IAS

Flowchart: Trauma identified? (Yes/No) → Repair not required / Classify injury, Use repair technique appropriate for injury, Use local and/or regional anaesthesia as appropriate

First degree repair

- If haemostasis evident and structures apposed, suturing not required
- Repair skin with continuous subcuticular sutures or consider surgical glue
- Avoid large volumes of local anaesthetic for clitoral tears

Second degree repair

- Repair muscle with continuous, non-locked sutures
- Use absorbable synthetic suture material
- If skin apposed after suturing muscle layer, suturing of skin is not required
- If skin not apposed after suturing muscle layer, suture the skin

OASIS

- Undertake repair in theatre except in exceptional cases
- Avoid figure of eight sutures
- Trim suture ends and bury knots in deep perineal muscle to avoid suture migration
- Repair of EAS:
 - Use monofilament or modern braided sutures
 - Full thickness EAS tear, use overlapping or end-to-end method
 - Partial thickness EAS tear, use end-to-end method
- Repair of IAS:
 - Repair separately with interrupted or mattress sutures
 - Do not attempt to overlap IAS
- Repair of anorectal mucosa:
 - Use 3-0 polyglactin suture
 - Avoid polydioxanone sutures
 - Use either continuous or interrupted sutures

Perineal tear classification

First degree: Injury to the skin or vaginal epithelium only

Second degree: Injury to the perineum involving perineal muscles but not involving the anal sphincter

Third degree: Injury to perineum involving the anal sphincter complex

- **3a:** Less than 50% of EAS torn
- **3b:** More than 50% of EAS torn
- **3c:** Both EAS and IAS torn

Fourth degree: Injury to perineum involving the EAS, IAS and anal epithelium

Rectal buttonhole tear: Injury to rectal mucosa with an intact IAS

Third and fourth degree tears collectively known as OASIS

EAS: external anal sphincter; IAS: internal anal sphincter, OASIS: obstetric anal sphincter injuries

