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

Trauma identified?
- Yes
  - Classify injury
  - Use injury technique appropriate for injury
  - Use local and/or regional anaesthesia as appropriate
- No
  - Repair not required

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
- 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

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