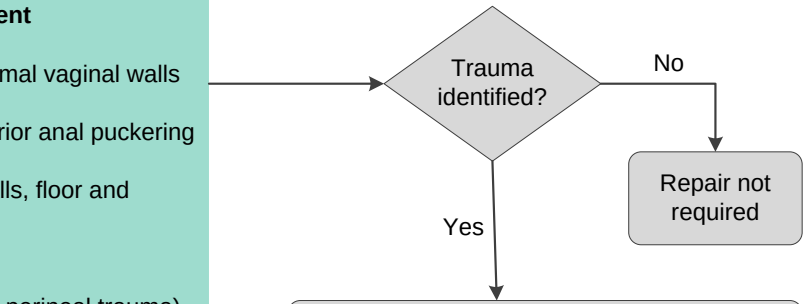
Perineal assessment and repair

General principles for perineal assessment and repair

- Provide privacy and warmth
- Seek consent prior to assessment and repair
- Communicate clearly and sensitively
- Position woman to optimise comfort and clear view of perineum with adequate lighting
- Perform assessment and repair as soon as practicable while maintaining mother-baby bonding
- Ensure adequate analgesia/anaesthetic throughout assessment and repair
- Clinician is competent to perform assessment and repair–refer to more experienced clinician as required

Perform a 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 (indicated if perineal trauma)
  - 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 rectal wall
  - Note detection of IAS damage



- Classify injury
- Discuss benefits/risks of repair/non-repair
- Use repair technique appropriate for injury
- Use local and/or regional anaesthesia

First degree repair

- If haemostasis evident and structures apposed, suturing not required
- If bleeding or skin not aligned suture using continuous non-locked subcuticular absorbable sutures or consider surgical glue
- Avoid large volumes of local anaesthetic for clitoral tears

Second degree repair

- Repair muscle with continuous, non-locked sutures
- Using 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
- PR exam to ensure sutures not penetrating anorectal mucosa

OASIS

- Repair in OR usually recommended
- 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

Third and fourth degree tears collectively known as OASIS

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 **OR**: operating room,

Queensland Clinical Guideline. *Perineal care.* Flowchart: F23.30-2-V4-R28