

Perineal trauma following vaginal delivery, including episiotomy (V6)

Guideline Readership

This guideline is relevant to midwives and doctors responsible for patients during intrapartum and immediate postpartum periods

Guideline Objectives

The guideline provides information to all obstetric & midwifery staff to enable the identification of extent of perineal trauma. Also, providing evidence of the most appropriate and safe method of management following parturition and during the postnatal period.

Other Guidance

- National Institute for Health and Clinical Excellence. (2014). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: www.nice.org.uk
- National Safety Standards for Invasive Procedures (NatSSIPs) 2015 Available at <https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf>
- Nursing & Midwifery Council (NMC) (2015) Standards. London: NMC <https://www.nmc.org.uk/standards/> accessed 01/04/2016
- Royal College of Obstetricians and Gynaecologists (RCOG) (2015) Guideline No.29 Third and fourth degree perineal tear, management. [Online] Available from: <http://rcog.co.uk> Accessed January 2016
- Royal College of Obstetricians and Gynaecologists. (2015). *Obtaining Valid Consent*. London: RCOG. <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/clinical-governance-advice-6/>
- Royal College of Obstetricians and Gynaecologists. (2008). *Presenting Information on Risk*. London: RCOG. Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/clinical-governance-advice-7/>
- Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press. Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/>

Compliant with NICE & RCOG recommendations for practice.

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Effective from: 17th May 2016

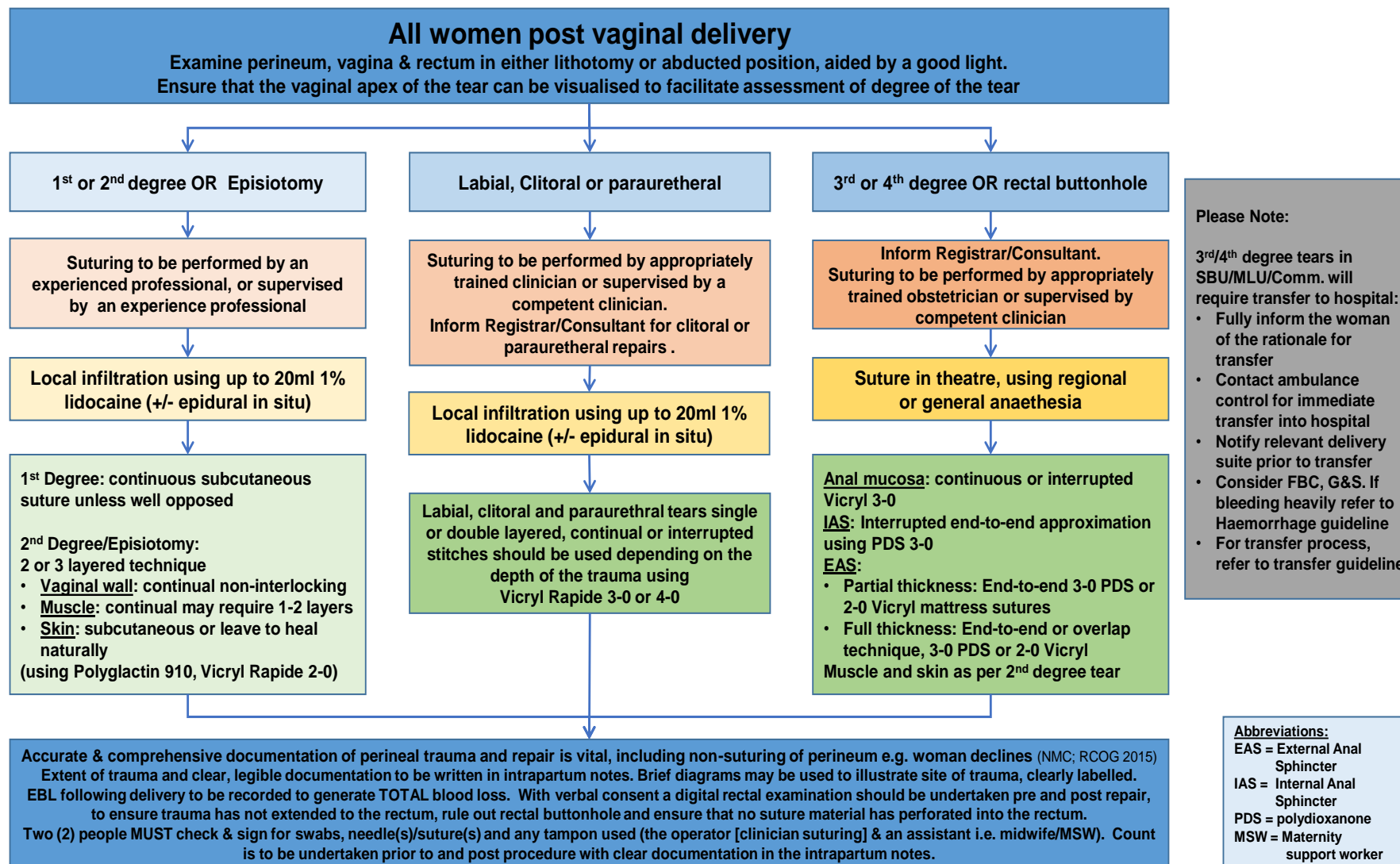
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1. Flowchart - Summary of perineal repair



2. Executive Summary & Overview

In the UK it is estimated that over 85% of women who have a vaginal delivery will sustain some degree of perineal trauma, and of these women 60-70% will experience suturing (Fitzpatrick et al 2007; Lone et al 2012). The process of vaginal delivery, especially operative vaginal delivery can tear vaginal attachments, rupture the anal sphincter, and cause pudendal nerve damage, which in turn can lead to incontinence and pelvic floor prolapse.

The rate of obstetric anal sphincter injuries (OASIS) has tripled from 1.8% to 5.9% from 2000 to 2012 but this seems to be a result of increased awareness and training and as such, at least in the short term, seems to reflect an improved quality of care through improved detection and reporting (RCOG 2015).

Known associated risk factors for severe perineal injury include Asian ethnicity, nulliparity, birthweight > 4kg, shoulder dystocia, occipito-posterior position, prolonged second stage and instrumental deliveries. The effect of perineal damage can have a major impact on women's health. Anatomically incorrect approximation of wounds or unrecognised trauma has been associated with long-term morbidity; consequentially, the mismanagement of perineal trauma is a source of obstetric litigation (RCOG, 2015). Nevertheless, a significant amount of postpartum maternal morbidity remains unreported to health professionals.

3. Body of Guideline

NB in cases of Female Genital Mutilation (FGM) please refer to relevant guideline.

Perineal anatomy

Anatomically, the perineum extends from the pubic arch to the coccyx. The perineal body is located between the vagina and the rectum, formed predominantly by the bulbocavernosus and transverse perineal muscle (Lone et al 2012).

Definition of spontaneous tears & assessment (see flowchart 1)

EAS: External Anal Sphincter

IAS: Internal Anal Sphincter

OASIS: Obstetric Anal Sphincter Injuries

Degree

Trauma

First

Injury to the **skin only and or vaginal mucosa only**

Second

Injury to the perineum involving **perineal muscles** but not involving the anal sphincter

Third

Injury to the perineum involving the **anal sphincter complex**

3a: less than 50% of EAS thickness torn

3b: more than 50% of EAS thickness torn

3c: Both EAS & IAS torn

Fourth

Injury to perineum involving the anal sphincter complex (EAS and IAS) and **anorectal mucosa**

Rectal Button Hole

Tear involving the rectal mucosa with an intact anal sphincter complex. **It is not to be defined as a fourth degree tear.** (RCOG, 2015)

Anterior trauma

Trauma involving the labia, anterior vagina, urethra or clitoris

Posterior trauma

Trauma involving the posterior vaginal wall, perineal muscles or anal sphincters and may include disruption of the anal epithelium.

All women having a vaginal delivery should have a systematic examination of perineum, vagina and rectum to assess severity of damage and to rule out an isolated rectal button hole.

If genital trauma is identified following birth, further systematic assessment should be carried out, including a rectal examination (RCOG 2015, NICE 2007). An experienced obstetrician, trained in the management of perineal tears, should examine all women who have had an instrumental delivery, or those who are deemed to have extensive perineal injury.

Before seeking consent for a test, treatment, intervention or operation, you should ensure that the person understands the nature of the condition for which it is being proposed, its prognosis, likely consequences and risks of receiving no treatment, as well as any reasonable or accepted alternative treatments. Uncertainties should be discussed and proposed treatment should be clearly documented in the intrapartum notes (RCOG, 2008, NHS England, 2015).

Verbal consent for this procedure is sufficient unless a third or fourth degree tear is present, in which case written consent is required. Women who request **not** to have their tear sutured must be given the opportunity to discuss their concerns, and be provided with information regarding the extent of trauma sustained, and how to seek advice in the future should concerns arise. In cases where the woman refuses postpartum perineal examination they must be informed of the potential risks which may occur if trauma is left undetected, and the potential risks of anal sphincter trauma. Any procedure that is declined requires clear documentation in the intrapartum notes.

Training

Practitioners who are appropriately trained are more likely to provide a consistent, high standard of perineal repair (RCOG, 2015). Therefore, all midwives and doctors undertaking and/or supervising perineal repair must be deemed competent, in line with the trusts requirements (refer to Training needs analysis-TNA).

Suture material

The most appropriate suture material for perineal repair is a rapid absorbable synthetic material (**polyglactin 910**) with significant reduction in perineal pain and suture removal. **Coated Vicryl Rapide 2.0 (polyglactin 910) suture is recommended** for patient comfort and short term wound support (7-10 days) (Ethicon, 2005; RCOG 2015). Labial, clitoral and paraurethral tears should be repaired using Vicryl Rapide 3/0 or 4/0. **See below for third and fourth degree tears.**

Principles of repair:

- Consent or refusal to be sutured must be documented clearly in the intrapartum notes following an informed discussion with the woman
- Local Safety Standards for Invasive Procedures (LocSSIPs) should be followed in all cases (NatSSIPs 2015); clearly checking: the patient, procedure, type of repair, any significant comorbidities, allergies, infection risk, equipment and any planned post procedural management.
- Suture should be undertaken as soon as possible following delivery to reduce bleeding and risk of infection
- Check equipment. Two (2) people **MUST** check & sign for swabs, needle(s)/suture(s) and any tampon used (the operator [clinician suturing] & an assistant i.e. midwife/Midwifery support worker [MSW]). Count is to be undertaken prior to and post procedure with clear documentation in the intrapartum notes.
- Ensure only x-ray detectable medium swabs are used. **DO NOT USE SMALL SWABS.**
- Examine perineum, vagina and rectum in either lithotomy or abducted position, aided by a good light.

- Ensure that the vaginal apex of the tear can be visualised to facilitate assessment of degree of tear
- Ask for more experienced assistance if in doubt regarding the extent of trauma or structures involved
- Women assessed as having 3rd/4th degree tear or difficult trauma, at Solihull Birth Unit or on the Midwifery Led Unit (Willow Suite) will require transfer to BHH delivery suite for suturing in theatre.
- Labial tears should be sutured especially when bilateral, to avoid labial fusion.
- Clitoral and paraurethral tears should be sutured by appropriately trained members of the obstetric team.
- Difficult trauma should be repaired by an experienced obstetrician in theatre under regional or general anaesthesia – insert an indwelling catheter for 24 hours to prevent urinary retention, and consider antibiotic prophylaxis. Document insertion of catheter on MEOWS chart.
- Ensure good anatomical alignment of the wound and give consideration to cosmetic results
- Rectal examination after completing the repair will ensure that suture material has not been accidentally inserted through the rectal mucosa, and must be undertaken after repair. If the woman declines rectal examination document clearly in the intrapartum notes.

Post repair advice: Inform the woman regarding the extent of trauma and type of repair. Also discuss pain relief, diet, hygiene and the importance of pelvic floor exercises and record this in the intrapartum notes (NICE 2014).

Method of repair

- In the case of first degree trauma, the wound should be sutured in order to improve healing unless the edges are well opposed (NICE 2014).
- Figure of eight stitches should be avoided as these are haemostatic and may lead to tissue necrosis.
- In the case of second degree trauma the muscle should be sutured in order to improve healing.
- For the vaginal wall and muscle layer use a continuous non-locking technique (NICE 2014).
- If the skin is well opposed after suturing the muscle there is no need to suture it (NICE 2014).
- If the skin does need suturing, use a continuous subcuticular technique (NICE 2014).
- In the case of labial, clitoral and paraurethral tears single or double layered, continual or interrupted stitches should be used depending on the depth of the trauma using Vicryl Rapide 3-0 or 4-0.

Analgesia

- Nonsteroidal anti-inflammatory (NSAID) rectal suppositories are associated with less pain up to 24 hours after birth and less additional analgesia is required (NICE 2014, Hedayati et al, 2003). Check patient allergies and medical status for appropriate prescriptions of analgesia.
- Midwives can prescribe Diclofenac for adult use according to the NMC exemptions, oral/PR for postpartum pain relief up to 48 hours after birth (NMC, 2010)
- Regular analgesia in the form of oral paracetamol and ibuprofen should be prescribed.

Episiotomy

The process of vaginal delivery, especially when accompanied by episiotomy or operative vaginal delivery, can tear vaginal attachments, rupture the anal sphincter, and cause pudendal nerve damage, which in turn can lead to incontinence and pelvic floor prolapse. There may be extension to third or fourth degree lacerations involving the anal sphincter, which have been independently linked to bowel incontinence. Routine episiotomy is therefore not recommended and should only be performed in carefully selected individuals (RCOG 2015).

Benefits and risks of performing an episiotomy

The evidence for the protective effect of episiotomy is conflicting. However, there is evidence that a mediolateral episiotomy should be considered with instrumental deliveries as it appears to have a protective effect on OASIS (RCOG 2015).

Where an episiotomy is indicated, the mediolateral technique is recommended, with careful attention to ensure that the angle is 60 degrees away from the midline when the perineum is distended (RCOG 2015)

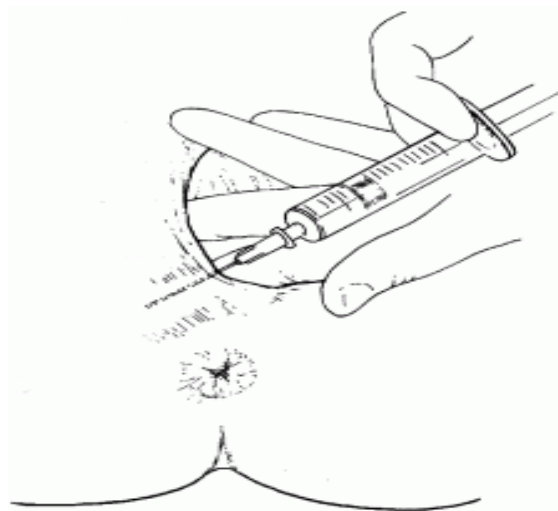
Performing an episiotomy

- Cleanse perineal area
- Provide emotional support and encouragement.
- Explain the procedure and obtain verbal consent
- Make sure there are no known allergies to lidocaine or related drugs.

Anaesthetise early to provide sufficient time for effect.

Infiltration

Diagram 1



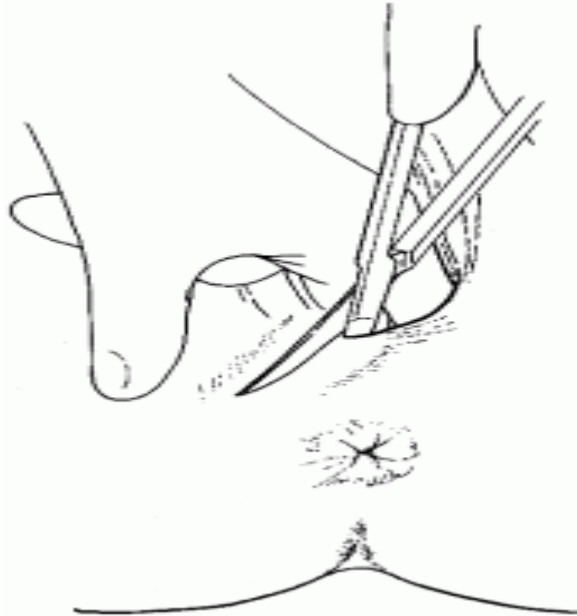
- Use local infiltration with Lidocaine or a pudendal block for instrumental delivery
- Infiltrate beneath the vaginal mucosa, beneath the skin of the perineum and deeply into the perineal muscle (see diagram 1) using about 10mls of 1% Lidocaine solution or related drugs. **Do not exceed maximum dose of 20mls of 1% Lidocaine.** Midwives can prescribe Lidocaine according to the NMC exemptions, subcutaneous/intramuscular for perineal infiltration (NMC, 2010)

Note: Aspirate (pull back on the plunger) to be sure that no vessel has been penetrated. If **blood is returned in the syringe**, remove the needle. Recheck the position carefully and try again. Never inject if blood is aspirated. The **woman can suffer seizures and death if intravenous (IV) injection of Lidocaine occurs.**

- Once Lidocaine insitu, wait 2 minutes and then pinch the incision site with forceps. If the **woman feels the pinch**, wait 2 more minutes and then retest.

Incision (episiotomy)

Diagram 2



- Wait to perform the incision until: the perineum is thinned out; and 3-4cms of the baby's head is visible during a contraction
- Wearing sterile gloves place two fingers between the baby's head and the perineum (see diagram 2)
- Using perineal scissors cut the perineum about 3-4cms in the **mediolateral direction at an angle of 60 degrees away from the midline when distended** (RCOG 2015).
- If using curved perineal scissors ensure the curved end is pointing away from the anus, to reduce the risk of the episiotomy extending towards the anus.
- Control baby's head and shoulders on delivery, ensuring that the shoulders have rotated to the midline to prevent an extension of the episiotomy

Repair of an episiotomy

Refer to above guidance for appropriate repair techniques.

Third and fourth degree tears

Third degree tears are defined as those involving the anal sphincter complex. Fourth degree tears are those that also include the rectal mucosa.

Anal incontinence is defined as any involuntary loss of faeces or flatus, or urge incontinence that is adversely affecting a woman's quality of life.

With increased awareness and training, there appears to be an increase in the detection of anal sphincter injuries. A trend towards an increasing incidence of third and fourth degree tears does not necessarily indicate poor quality care. It may indicate, at least in the short term, an improved quality of care through better detection and reporting (RCOG 2015).

Anatomy of the anal sphincter

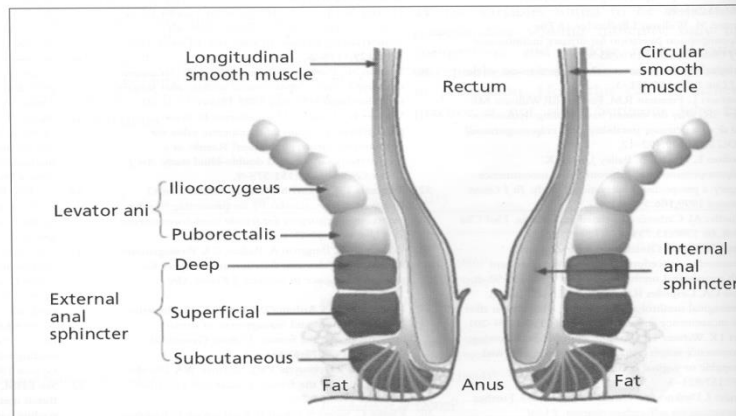


Figure 1 Diagrammatic representation of the anal sphincter

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Risk assessment

Risk factors for third and fourth degree tears have largely been identified in retrospective studies. The following factors are associated with an increased risk of third and fourth degree tear:

- Asian ethnicity
- Nulliparity
- Birth weight > 4kg
- Shoulder dystocia
- Occipito-posterior position
- Prolonged second stage of labour
- Instrumental delivery
(RCOG, 2015)

Obstetric anal sphincter injury prevention

- Women should be informed that the evidence for the protective effect of an episiotomy is conflicting.
- Mediolateral episiotomy should be considered in instrumental deliveries.
- Where an episiotomy is indicated, the mediolateral technique is recommended, with careful attention to ensure that the angle is 60 degrees away from the midline when the perineum is distended.
- Perineal protection at crowning can assist with reducing the risk of episiotomy extension.
- Warm compression during the second stage of labour reduces the risk of OASIS.
- The data regarding the protective effect of perineal massage are inconclusive.
(RCOG, 2015)

Prognosis

Several randomised controlled trials have been carried out since 2000 comparing overlap and end-to-end techniques of EAS repair. Low incidences of symptoms of anal incontinence have been reported in both arms of the trials with 60-80% of women described as asymptomatic at 12 months (RCOG 2015).

Method of repair of anal sphincter and postoperative care:

- 1) Local Safety Standards for Invasive Procedures (LocSSIPs) should be followed in all cases (NatSSIPs 2015) clearly checking: the patient, procedure, type of repair, any significant comorbidities, allergies, infection risk, equipment and any planned post procedural management.
- 2) 3rd and 4th degree repair should be carried out with written consent (RCOG, 2008) in an operating theatre, with good light, under regional or general anaesthetic, by an appropriately trained clinician or under supervision with an assistant if required.
- 3) Figure of eight sutures should be avoided because they may cause tissue ischaemia (RCOG 2015).
- 4) After careful vaginal/rectal examination, first repair torn anal epithelium if necessary, with continuous or interrupted Vicryl 3/0 (Ethicon) sutures.
- 5) Repair internal anal sphincter separately using end-to-end approximation with interrupted 3/0 PDS (polydioxanone). Identify it as white 'chicken-like' tissue.
- 6) Partial thickness external anal sphincter (EAS) injury is repaired with end-to-end technique with 3/0 PDS or 2/0 Vicryl mattress sutures.
- 7) Full thickness EAS injury can be repaired with either an end-to-end or overlap technique.
- 8) Reconstruct the perineal muscles carefully with Vicryl rapide 2/0 to support the sphincter repair. Bury PDS knots and suture ends completely. Repair vaginal mucosa and perineal skin. Perform careful vaginal and rectal examination.
- 9) Clear documentation/diagrams of the anatomical structures involved, method of repair, suture materials used, and that all swabs and instruments are accounted for is essential.
- 10) A Foley's catheter should be considered for 24 hours especially if instrumental delivery and regional anaesthesia, to avoid urinary retention.
- 11) Antibiotics, prophylaxis:
Co-Amoxiclav (Augmentin) 1.2g and Metronidazole 500 mg IV in theatre followed by Metronidazole 400mgs Oral, tds for 5 days. For patients with penicillin allergy Gentamicin 160mgs stat dose and Metronidazole 500mg IV, followed by Metronidazole 400mgs Oral, tds for 5 days
- 12) Laxatives in the form of Docusate Sodium 100mg bd orally (can take up to 500mg daily for chronic constipation) is recommended in the post-operative period for up to 10 days to reduce the risk of wound dehiscence. Bulking agents should not be given routinely (RCOG 2015).
- 13) Analgesia such as Diclofenac 100 mg PR is recommended, providing there are no contraindications. Avoid opiate-containing analgesics.
- 14) Consider TED stockings and Clexane if risk factors for thrombo-embolism (see venous thromboembolism [VTE] guideline)
- 15) All women should be seen postoperatively by a doctor for debriefing, ideally by the surgeon performing the repair. Clear documentation is vital and MUST be recorded in the intrapartum notes.
- 16) The woman can be discharged before she has had a bowel action.
- 17) All women who have sustained third/fourth degree tears should be seen for follow up at 12 weeks in postnatal/gynaecology clinic to see a registrar or consultant. Refer to physiotherapist. Active questioning about bowel symptoms is necessary. Midwife/General Practitioner (GP) to refer woman to urogynaecologist and/or further physiotherapy where necessary. Colorectal surgeons should be consulted if more advice needed by the obstetric consultant.

Subsequent vaginal deliveries, management issues to consider:

- Involve specialists including colorectal surgeons in decision-making if needed.
- All women who had a third/fourth degree tear in their previous pregnancy should be counselled regarding the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery.
- If asymptomatic there is no clear evidence as to the best mode of delivery. In general a normal delivery by a senior midwife or doctor is advised.
- If mild symptoms, consider anal endosonography and manometry and possible elective caesarean.
- With abnormal endoanal ultrasonography or manometry and significant incontinence, the options are elective caesarean section, or normal delivery and secondary sphincter repair.

There is no evidence that prophylactic episiotomy prevents a recurrence of sphincter rupture. However, if risk factors such as large baby, Occiput-posterior (OP) position, shoulder dystocia, fibrotic band or inelastic perineum occur an episiotomy should be strongly considered (RCOG 2015).

Documentation and Postnatal Follow up care for all women with perineal trauma

Accurate and comprehensive documentation of Perineal trauma and repair is vital, including non-suturing of perineum; e.g. woman declines (NMC & RCOG, 2015). Extent of trauma and clear, legible documentation to be written in the intrapartum notes. Brief diagram(s) may be used to illustrate site of trauma if this supports the documentation, clearly labelling the diagram. Check and record swab count, needle count, tampons (if used) and estimated blood loss (EBL), this should be undertaken by two (2) people, one who is the clinician (operator) and the other an assistant (e.g. MSW). Advice should be given to the woman on resuming intercourse when she feels comfortable. Two trials on sexual function following episiotomy and tears found that women who had an episiotomy were more likely to resume intercourse within a month than those women that had tears (NICE, 2014). Advice on pain relief, hygiene, being aware of signs of infection, pelvic floor exercises and diet should be documented clearly in the intrapartum notes (RCOG 2015).

Observation of perineal healing will be predominantly undertaken by hospital and community midwives. However, on discharge from the maternity unit following a third or fourth degree tear a referral to a Registrar or Consultant must be made for a follow up appointment for 6 weeks to 3 months in either a postnatal or gynaecology clinic for a check of the repair and any problematic wounds. A referral to a physiotherapist is also made on discharge.

Postnatal Readmission

Admitting staff must clearly document in the maternal notes the reason for readmission, referrals made and the reviewing doctor must record a clear management plan. Also complete a DATIX form (incident reporting system) regarding the readmission into hospital and the rationale.

4. Reason for Development of the Guideline

The Guideline provides information to all clinicians for the management of women who have experienced perineal trauma following a vaginal delivery.

5. Methodology

Development of all guidelines adheres to a process of examining the best available evidence relevant to the topic, incorporating guidance and recommendations from national and international reports.

Finalised guidelines will ultimately be approved and ratified by the directorate locally.

6. Implementation in HEFT & Community

Following approval the guideline will be disseminated and available for reference to all members of the multidisciplinary team via the Trust and Obstetric intranet site; also paper copies will be stored in a marked folder within a designated clinical area. Annual trust midwifery days reviews the current literature and standards of care expected for the repair of perineal trauma and cascades to midwives through active presentations, discussion and hands-on care using simulation models.

7. Monitoring & Suggested Quality Standards

Adherence and efficiency of clinical guideline will be monitored through regular clinical audit. Multidisciplinary auditing of a clinical guideline will be allocated and overseen by the Clinical Audit Lead.

A monthly report of the numbers of women having third and fourth degree tears is presented to the Obstetric & Gynaecology governance group by Maternity clinical governance.

Element to be monitored	Tool	Frequency
<p>Minimum requirements:</p> <ul style="list-style-type: none"> Who can perform the repair (training records) & maternity expectations for staff training Consent for all types of repair Management of 3rd & 4th degree tears Debriefing of patients who undergo repair in theatre in the postoperative period by a doctor (ideally person performing the repair) Record keeping in relation to <u>all</u> types of perineal trauma, including when non-suturing is applicable Documentation of systematic assessment of perineum and lower for accurate evaluation of trauma sustained and information given regarding support and follow up appointments following all types of perineal repair, where necessary Methods and materials used in perineal repair Monitoring of rate and cause of women who return with problems following perineal repair 	<p>Maternity information system</p> <p>Proforma</p> <p>Maternity records</p> <p>Training reports</p> <p>Datix incident reporting system</p>	<p>Annual review of all health records of women who have had a third or fourth-degree tear</p> <p>Annual review of 1% or 10 sets of health records (whichever is the greater) of women who have delivered</p> <p>Additional evidence will be required to demonstrate implementation of training, with attendance levels at a minimum of 75%</p>

Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
<p>The completed reports will go to the clinical governance group and be presented at the departmental audit meetings.</p> <p>Action plans will be documented in minutes.</p>	<p>The leads will use the electronic tracker system for audit to track action plans, which will have stated time frames</p> <p>NB Training report not on the electronic tracker system</p>	<p>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</p> <p>Non-compliance to actions from audit will be escalated to the Directorate governance meetings; further non-compliance will be finally escalated to the Women's and Children's Quality and Safety for resolution.</p>

Following clinical audit of a guideline, an addendum to change in clinical practice may be necessary. Any change to a clinical guideline requires that it must be ratified by the directorate locally.

Review dates for guidelines will be set at a period of three years; however this set period can be overridden in light of new clinical evidence.

All unused/previous guidelines will be logged and archived electronically, and in paper format within the trust.

8. References

- Fitzpatrick M and O'Herlihy (2007) Postpartum care of the perineum. *The Obstetrician & Gynaecologist* 2007; 9:164-170
- Gentlebirth (2005) Benefits and risks of episiotomy. [Online]. Available from: <http://www.gentlebirth.org/format/woolley.html> Accessed 01/04/2016
- Goldberg, J. and Sultana, C. (2004) Preventing perineal lacerations during labour. *Contemporary OB/GYN* September 2004 [Online].
- Hartmann, K., Viswanathan, M., Palmieri, R., Gartlehner, G., Thorp, J. and Lohr, K.H. (2005) Outcomes of routine episiotomy. A Systematic Clinical Review. *JAMA*. Vol.293, No.17, May 4 [Online]. Available from: <http://jama.ama-assn.org/cgi/content/short/293/17/2141> Accessed 1/12/05
- Hedayati, H., Parsons, J. and Crowther, C.A. (2003) Rectal analgesia for pain from perineal trauma following childbirth. *Cochrane Database Syst Rev*. 2003; (3); CD003931 [Online]. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/15383107> Accessed 01/04/2016
- Kettle, C. and Johanson, R.B. (2004) Continuous versus interrupted sutures for perineal repair (Cochrane Review) *The Cochrane Library*, Issue 3, 2004 [Online]. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23152204> Accessed 01/04/2016
- King's Fund. (2008). *Safe Births: Everybody's business - Independent Inquiry into the Safety of Maternity Services in England*. London: King's Fund. Available at: www.kingsfund.org.uk
- Lone F, Sultan A and Thakar R (2012) Obstetric Pelvic Floor and Anal Sphincter Injuries. *The Obstetrician & Gynaecologist*. 2012; 14:257-66.

- National Institute for Health and Clinical Excellence. (2014). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: www.nice.org.uk
- NHS England (2015) National Safety Standards for Invasive Procedures (NatSSIPs). Available at <https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf>
- Nursing & Midwifery Council (NMC) (2015) Standards. London: NMC <https://www.nmc.org.uk/standards/> accessed 01/04/2016
- Royal College of Obstetricians and Gynaecologists (RCOG) (2015) Guideline No.29 Third and fourth degree perineal tear, management. [Online] Available from: <http://rcog.co.uk> Accessed January 2016
- Royal College of Obstetricians and Gynaecologists. (2015). *Obtaining Valid Consent*. London: RCOG. <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/clinical-governance-advice-6/>
- Royal College of Obstetricians and Gynaecologists. (2008). *Presenting Information on Risk*. London: RCOG. Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/clinical-governance-advice-7/>
- Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press. Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/>
- Thiagamorthy G, Johnson A, Thakar R, Sultan AH. National survey of perineal trauma and its subsequent management in the United Kingdom. *Int Urogynecol J*. 2014 Dec;25(12):1621-7.

Meta Data

Guideline Title:	Management of perineal trauma following vaginal delivery
Guideline Sponsor:	Obstetrics & Gynaecology Directorate
Date of Approval:	21 st April 2016
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Review Date:	17 th May 2019
Related Policies/Topic/Driver	<ul style="list-style-type: none"> • Female Genital Mutilation (FGM) • Instrumental Vaginal delivery • Maternity record keeping (Procedure) • Shoulder Dystocia • Training needs analysis(TNA) • Transfer guideline • Venous thromboembolism guideline

Revision History

Version No.	Date of Issue/Review date	Author(s)/Reviewer(s)	Reason for Issue
1	February 2007	M Dobson, B Page, C Rhodes	Merger
2	December 2008	M Dobson	Changes in prophylactic antibiotics for 3 rd & 4 th degree tears, & use of laxatives from Lactulose to sodium docusate page 12
3	November 2010	C. Austin M Dobson	Review/Addendums: p.6 – rectal examination - consent (RCOG 2008) - midwifery training - use of large swabs p.9 - use of curved perineal scissors p.11- prophylactic antibiotics p.12- advice for resuming intercourse - postnatal follow up for 3/4 th degree Tears - care of postnatal readmissions p.13- monitoring tool / audit
4	January 2012	M. Dobson C. Austin	Review p.6 – documentation consent/refusal p.7 – maternal position when visualising tear p.7&8 – midwife exemption, Diclofenac & Lidocaine
5	October 2012	M. Dobson	Addendum: Two people checking and signing for swabs & needles/sutures Flowchart updated to reflect changes Monitoring & audit updated.
6	May 2016	Ganga Verma – ST5 O&G	Addition of recommendations from NICE CG190 2014, RCOG 2015 GG29 & NatSSIPs 2015 PR recommended post delivery for all to rule out rectal button hole tears. Suggested angle for mediolateral episiotomy now 60 degrees when perineum is distended. Protective effects of episiotomy. New section on prevention of 3 rd and 4 th degree tears. Prophylactic laxatives following third degree tears to no longer include bulking agents (fybogel)

Clinical Director:

Signed:



Name: Katherine Barber

Date: 12th May 2016