



OBSTETRICS AND GYNAECOLOGY DIRECTORATE  
CLINICAL PRACTICE GUIDELINE

# Perineal care and repair: Protection, assessment and management

This document should be read in conjunction with the [Disclaimer](#)

This guideline must be read in conjunction with WNHS Policy: [Procedural Count: Management and Procedure](#) and [ACSQHC Clinical Care Standard: Severe \(Third and Fourth Degree\) Perineal Tears](#).

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# Protection of the perineum

The following care elements have been identified as beneficial and are important to be consistently offered to all women having a vaginal birth when clinically appropriate<sup>2</sup>:

1. Apply a warm compress-
  - During perineal stretching/crowning in second stage of labour
2. Encouraging a slow controlled birth
  - For spontaneous vaginal birth- gentle verbal guidance, support the perineum with a warm compress, apply counter pressure on the fetal head with non-dominant hand. Gentle traction to release anterior shoulder if shoulders do not deliver spontaneously; allow posterior shoulder to be released following the curve of Carus
3. Technique when performing an [episiotomy](#) (if episiotomy is indicated)
  - At crowning using a mediolateral incision at a minimum 60° angle from fourchette
  - Offer an episiotomy if forceps or vacuum are required and this is the woman's first birth (due to increased risk of third and fourth degree tears)
4. Assessing for perineal tears (with consent)
  - All women should have a genito-anal examination following birth performed by an experienced clinician and include a per rectum (PR) examination
5. Grading of perineal tears- according to RCOG grading
  - Reviewed by a second experienced clinician to confirm diagnosis and grading

## Notes-

- Women may decline any care element if they choose<sup>2</sup>
- If water birth, the warm compress and hands on technique cannot be applied<sup>2</sup>

For further details on care elements, refer to [The How to Guide: WHA CEC Perineal Protection Bundle](#) (external website, PDF, 9.2MB) (page 10 for summary).

# Episiotomy and infiltration of the perineum

## Key points

1. Selective use of the episiotomy is preferable rather than routine use of episiotomy.<sup>4</sup>
2. A mediolateral episiotomy is associated with less risk for injury to the anal sphincter than a midline incision. When an episiotomy is indicated (e.g. if indicated at an instrumental birth), carefully angling the cut away from the midline using the mediolateral technique is recommended.<sup>5</sup> A lower risk of third degree tear is associated with a larger angle of episiotomy (i.e. at the 8 o'clock position / 60 degrees).
3. An episiotomy is not required routinely for preterm birth. The decision to perform an episiotomy is based on individual needs.
4. Episiotomy is associated with a potential reduction in pelvic floor muscle function.
5. Routine episiotomy does not prevent pelvic floor damage<sup>4</sup> leading to incontinence.

## Indications for episiotomy

### Absolute

- To facilitate birth in cases of non-reassuring fetal heart rate.<sup>1</sup>

### Relative

- Rigid perineum – rigid musculature may cause prolonged delay in second stage<sup>1</sup>
- Preventing severe perineal trauma<sup>1</sup> – when associated with signs of severe perineal trauma (e.g. 'button-holing'),<sup>1</sup> a history of surgical repair of the bladder or fistula.
- Reducing maternal effort – e.g. severe cardiac disease, epilepsy or hypertension
- Episiotomy can be considered in shoulder dystocia if the clinician feels it will reduce maternal trauma and improve access for delivery
- Operative vaginal delivery - based on clinical judgement
  - Offer an episiotomy if forceps or vacuum is required and this is the woman's first vaginal birth (increased risk of third and fourth degree tears).<sup>2</sup>

## Equipment

- 1 x 20mL syringe
- 1 x 19 gauge needle
- 1 x 22 gauge needle (infiltration needle)
- 10 mL 1% Lignocaine
- Mayo episiotomy scissors

## Procedure

### 1 Preparation

Explain the procedure and indication for the intervention to the woman.  
Obtain verbal consent.

### 2 Infiltration

- 2.1 Using the syringe and 19 gauge needle, draw up 10mL of 1% Lignocaine.  
Check the medication and dosage with an assistant.
- 2.2 Insert two fingers into the vagina between the presenting part and the skin.  
For a medio-lateral episiotomy, direct the needle at an angle of approximately 45-60° for 4 to 5 cm at the same skin depth.  
Aspirate the syringe to confirm that a blood vessel has not been cannulated.  
While withdrawing the syringe, continuously inject approximately 3 mL of local anaesthetic into the area.  
Leave the tip of the needle still inserted in the perineal area.
- 2.3 Repeat this step twice by redirecting the needle either side of the initial injection so that a fan shaped area is anaesthetised.
- 2.4 Withdraw the needle and apply pressure over the injection site.

### 3 Cutting an episiotomy

- 3.1 Insert the index and middle finger in between the presenting part and the perineum, pointing downwards.  
Take the open scissors and position between the fingers, over the area intended for incision. Ensure there is good vision of the perineum and the incision is away from the anus and Bartholin's gland.  
Make a single, deliberate cut 3 to 4 cm into the perineum at the height of the contraction at crowning<sup>2</sup>.  
The incision should start midline from the fourchette, and extend outwards in a medio-lateral direction, avoiding the anal sphincter.<sup>1</sup> Perform at a minimum 60 degree angle from the fourchette<sup>2</sup>  
Withdraw the scissors carefully.
- 3.2 Control the delivery of the presenting part and the shoulders.
- 3.3 Apply pressure to the episiotomy between contractions with a sterile combine if there is a delay in the birth.

# Initial assessment of perineum following vaginal birth

## Key point

1. The woman must consent to all procedures when assessing the perineum

## Procedure

1. Examine perineal and anal area for trauma using sterile solution and abdominal sponge / swab
  - Examination is to be performed and graded by an experienced practitioner and reviewed respectfully by a second experienced clinician to confirm diagnosis and grading if necessary
2. Perform a rectal examination on all women, including those with an intact perineum<sup>2</sup>
3. Trauma to be graded according to RCOG grading guidelines (see below)

## Trauma / tear classification<sup>5</sup>:

- 1<sup>st</sup> degree- Injury to perineal skin and / or vaginal epithelium
- 2<sup>nd</sup> degree- Injury to perineum involving perineal muscle but not anal sphincter
- 3<sup>rd</sup> degree- Injury involving the anal sphincter complex
  - 3a – Less than 50% external anal sphincter (EAS) torn
  - 3b – More than 50% EAS thickness torn
  - 3c – Both EAS and internal anal sphincter (IAS) torn
- 4<sup>th</sup> degree – Injury that involves the anal sphincter muscles and anorectal mucosa

## Notes-

- If there is a tear that involves only the rectal mucosa, and there is an intact anal sphincter complex (Buttonhole tear), then this and its repair should be documented as a separate entity. If not identified and repaired, it may cause a rectovaginal fistula.<sup>5</sup>
- If there is doubt to the degree of a third degree tear, classify it to the higher degree.<sup>5</sup>

# Managing perineal trauma and care

## Suturing: Episiotomy and genital lacerations

### Key points

1. All staff must be able to demonstrate clinical competence in suturing an episiotomy and/or genital laceration before undertaking the procedure without supervision.<sup>6</sup> See also
  - Midwives- [DNAMER competency requirements](#)
  - Medical- Competence is demonstrated by formal credentialing whereby all junior medical staff must be observed and assessed by a Registrar or above
2. Repair of the perineum should be undertaken as soon as possible<sup>2</sup> to decrease the risk for infection and blood loss.<sup>1</sup> The exception to this is following immersion in water during labour and / or a water birth. In this instance suturing should be delayed for up to 1 hour due to water saturation of the tissues<sup>7</sup> unless active bleeding needing immediate repair.
3. There is limited evidence that not suturing first or second-degree perineal trauma is associated with poorer wound healing at 6 weeks. There is no evidence as to long term outcomes.
4. With a first-degree tear if the skin edges are not well opposed, women should be advised that the wound should be sutured to improve healing.
5. In the case of second-degree tears, standard management is to offer suturing but this can be discussed with the patient in the context of the extent of the tear and bleeding.
6. Undertaking the suturing of an episiotomy or genital laceration is an aseptic procedure.
7. Radio-opaque abdominal swabs and tampons must be used (and counted) at all times.
8. The operator and the assistant are equally responsible for ensuring that all equipment used, including 'sharps', are accounted for at the end of the procedure i.e. signed and documented on the MR275 or MR270.

Standardised checking processes outlining the responsibilities for the operator and assistant are contained in the following documents which **must be read in conjunction with this guideline [RCA Recommendation]**:

- WNHS Policy: [Procedural Count: Management and Procedure](#)
  - Repair in theatre: Perioperative: [Surgical Count: Management and Procedure](#) (available to WA Health employees through HealthPoint)
9. The operator is responsible for safe disposal of all 'sharps' used prior to leaving the room.

10. Continuous rather than interrupted sutures for repair of the vagina and perineal muscles with subcuticular suturing to the skin is associated with reducing short term perineal pain.<sup>8</sup>
11. Use of an absorbable synthetic suture material such as polyglycolic acid and polyglactin 910 (Vicryl or Polysorb) is associated with less perineal pain, analgesia use, dehiscence and need for resuturing, but is linked to increased suture removal when compared to catgut.<sup>1</sup>
12. A more rapidly absorbed synthetic suture material (Vicryl Rapide™) when compared to standard Vicryl material is associated with less perineal pain with ambulation or need for analgesia at 10-14 days postpartum.<sup>1</sup>
13. Vicryl Rapide™ is **not** the suture of choice for women with an increased BMI rather Polysorb or Vicryl should be used. Manufacturers advice, due to the rapid loss of tensile strength, Vicryl Rapide should not be used where extended approximation of tissues under stress is required or where wound support beyond 7 days is required.
14. Unidentified perineal trauma can lead to post-partum haemorrhage (PPH), vulvovaginal haematoma, shock, anal incontinence, wound infection, septicaemia, or rectovaginal fistula.<sup>9</sup>
15. Use of non-steroidal anti-inflammatory drugs (NSAID) rectal suppositories is associated with reduced intensity of perineal pain in the first 24 hours after birth, and less additional analgesia is required within the first 48 hours following birth.<sup>10</sup>
16. Women who have undergone deinfibulation during labour are not to be reinfibulated.<sup>11</sup>

## Equipment

- Sterile perineal suture pack
- 0.05% Chlorhexidine solution
- Syringe 20mL
- Needles: 19 gauge (drawing up needle), 22 gauge infiltration needle
- Local anaesthetic: 1% Lignocaine
- Suture material as requested by operator
- Lubricant
- Plastic apron, protective face shield, sterile gown and gloves
- Adequate light source, stool, nitrous oxide and oxygen gas apparatus

### Extra equipment that may be required includes:

- Radio-opaque tampon (Vaginal plug X-Ray Detectable (XRD))
- Rectal NSAID suppository, if not contraindicated
- Jackson retractors
- Extra artery forceps
- In-dwelling catheter (IDC) and pack for insertion

## Procedure

### 1 Preparation

- 1.1 Explain the procedure. Obtain maternal consent.
- 1.2 Place the woman in a dorsal or lithotomy position and ensure good lighting. Operator to be mindful of manutention (manual handling) principles.
- 1.3 Ensure the woman is warm and as comfortable as possible.
- 1.4 Don protective face shield and apron, once scrubbed don sterile gown and sterile gloves
- 1.5 Perform and document an initial count of all swabs and equipment to be used with an assistant and document on the MR 275 or MR270  
Document all additional materials, tampons (vaginal plugs XRD), instruments or needles required during the procedure
- 1.6 Swab the perineal area with the 0.05% chlorhexidine solution
- 1.7 Place a sterile lithotomy drape over the area to be sutured.

### 2 Analgesia

Ensure the area to be sutured is adequately anaesthetised by:

- Offering the woman N<sub>2</sub>O & O<sub>2</sub> prior to, and during, preparation and infiltration of the area,
- Offering the woman an epidural top-up or
- Infiltrating with local anaesthetic
  - Ensure the woman has no allergy prior to infiltration of local anaesthetic
  - Withdraw the plunger of the syringe back prior to injecting 10-20mL of local anaesthetic slowly to prevent accidental injection into a blood vessel

Allow time for analgesia to take effect before continuing.

### 3 Procedure

- 3.1 A radio-opaque vaginal tampon (XRD vaginal plug) may be inserted. Ask the assistant to record its insertion. It must be secured to the drape with the artery forceps attached to the tape.  
Observe for excessive blood loss during and following the procedure.
- 3.2 Examine the area systematically to identify and classify the perineal trauma.  
When the assessment discloses extended perineal trauma see section: [Third and Fourth Degree Perineal Trauma Management](#).
- 3.3 Identify the apex of vaginal trauma and insert first suture 1cm above this point.

3.4 Using a continuous suture, repair the vaginal epithelium first, followed by the perineal muscle, and finally the skin. **Note:** two layers of muscle sutures may be required. Ensure:

- sutures are not over-tightened
- clots are removed from the wound
- dead spaces are not obscured
- hymenal remnants are not sutured

#### **4 After completion of suturing**

4.1 Remove the radio-opaque vaginal tampon (XRD vaginal plug) if used

4.2 Check:

- haemostasis has been achieved
- wound edges are apposed

4.3 Perform a vaginal and rectal examination.

4.4 Offer rectal NSAID suppositories for pain relief if there are no contra-indications.

4.5 Clean and dry the perineal area. Apply a pad.

4.6 Gently and simultaneously remove the woman's legs from the lithotomy position. Position the woman comfortably.

4.7 Perform and document a count of all instruments, swabs, and tampons with a second person and record the count on the MR275 or MR270.

4.8 Ensure regular perineal ice packs, analgesia and aperients have been charted.

#### **5 Perineal comfort measures**

5.1 See section in this document: [Perineal Postnatal Care](#)

**6 Documentation:** Document the perineal repair

#### **7 Education**

Discuss the following:

- type of trauma, method of repair and follow-up<sup>12</sup>
- wound healing,<sup>12</sup> suture absorption time
- pain relief<sup>12</sup>
- diet/fluids, rest, and personal hygiene<sup>12</sup>
- resumption of sexual intercourse
- signs of wound infection or breakdown and to seek medical review (e.g. GP) if these develop<sup>12</sup>

Ensure the woman has a copy or link to the [Pregnancy, Birth and your Baby Book](#) (PDF, 7.7MB). Refer her to section 'After the Birth of Your Baby: 'The Perineum'.

## Third and fourth degree perineal trauma management

### Background

Obstetric damage to the anal sphincter includes both third and fourth degree perineal tears.<sup>13</sup> Third degree perineal tears are defined as partial or complete disruption of the anal sphincter muscles, which may involve either or both the external anal sphincter (EAS) and internal anal sphincter (IAS) muscles.<sup>5</sup> A fourth degree tear injures the anal sphincter muscles with a breach of the ano-rectal mucosa.<sup>13</sup>

See section: [Trauma / Tear Classifications](#)

### Risk factors

There are risk factors associated with obstetric anal sphincter injury, however known risk factors do not always allow tear prediction or prevention.<sup>5, 14</sup> Taking an overall risk of 1% of vaginal births, the following factors are associated with an increased risk of a third degree tear<sup>14</sup>:

- Birth weight > 4kg<sup>2, 5, 13, 14</sup>
- Occipito-posterior position<sup>2, 5, 13, 14</sup>
- Nulliparity<sup>5, 14</sup>
- Shoulder dystocia<sup>2, 5, 14</sup>
- Induction of labour<sup>2, 14</sup>
- Forceps birth<sup>13, 14</sup>
- Midline episiotomy<sup>13, 14</sup>
- Second stage > 1 hour<sup>14</sup>
- Vacuum birth<sup>14, 15</sup>
- Asian<sup>5</sup>/ Indian<sup>2</sup> ethnicity
- Previous 3<sup>rd</sup> degree tear<sup>2</sup>
- Posterior fourchette to mid-anus <2.5cm<sup>2</sup>

### Examination

- For systematic examination see sections “[Initial Assessment of Perineum](#)” and [Trauma / Tear Classifications](#).
- If there is doubt to the degree of third degree tear, classify it to the higher degree.<sup>5</sup>

### Repair

#### Preparation

- Repair of third and fourth degree tears needs to be carried out by an appropriately trained practitioner, in an environment that provides adequate lighting and visualisation of the perineum<sup>14</sup>
- Third and fourth degree repairs should be conducted in the operating theatre where there is appropriate lighting, aseptic conditions, instruments and assistance.<sup>5</sup> Additionally, adequate anaesthesia (regional or general) is available, allowing the anal sphincter to relax which is essential for the retrieval of the retracted torn ends of the anal sphincter, for realignment and repair without tension.<sup>5</sup>
- During the repair consent process the woman should be informed that the extent of her perineal/anal trauma might not be known until she is assessed under adequate anaesthesia.
- Preoperative antibiotics as per “[Antibiotics](#)” section below

## Suture material

- 3-0 polyglactin (Vicryl or Polysorb) should be used to repair the anorectal mucosa as it may cause less irritation and discomfort than polydioxanone (PDS) sutures.<sup>5</sup>
- For repair of the EAS and/or IAS muscle, use monofilament sutures such as 3-0 PDS or modern braided sutures such as 2-0 polyglactin.<sup>5</sup>
- Rapidly absorbed suture material is **not** appropriate for 3<sup>rd</sup> and 4<sup>th</sup> degree tears. Use a slow absorbing suture material, such as 2-0 or 3-0 Polysorb.

## Repair technique / method

- A continuous non locking suturing technique to oppose each layer (vaginal tissue, perineal muscle and skin) is associated with less short term pain<sup>8</sup> compared to traditional interrupted method.
- Using a subcuticular method to the skin avoids the collections of nerve endings found in the superficial skin layer<sup>1</sup>; in addition, the reactionary oedema is transferred through the whole length of the suture rather than interrupted sutures which are transverse across the wound.

## Documentation

- Documentation of the repair should include the anatomical structures involved, repair method, suture materials used,<sup>5</sup> and account for instruments, sharps and swabs, and level of supervision.<sup>14</sup>

## Antibiotics<sup>16</sup>

### PRE-operative antibiotics

Give a single pre-operative dose of antibiotic before the repair of a third and fourth degree tear. Use:

- Cefazolin 2g intravenously. Do not give additional intravenous doses once the procedure is completed.  
PLUS
- Metronidazole 500mg intravenously. Do not give additional intravenous doses once the procedure is completed.

**For patients with immediate severe or delayed severe hypersensitivity to penicillins:** Use:

- Clindamycin 600mg intravenously.

### POST-operative antibiotics

The role of post-operative antibiotic therapy is unclear, but therapy is recommended following anal sphincter repair because infection in this setting carries a high risk of anal incontinence and fistula formation. Use:

- Amoxycillin + clavulanate 875+125 orally, 12 hourly for 5 days\*

**\*For patients with delayed non-severe hypersensitivity to penicillins use:**

- Cefalexin 500mg orally, 6 hourly for 5 days
- Plus**
- Metronidazole 400mg orally, 12 hourly for 5 days

**\*For patients with immediate (non-severe or severe) or delayed severe hypersensitivity to penicillins use:**

- Trimethoprim + sulfmethoxazole 160+800mg orally 12 hourly for 5 days
- Plus**
- Metronidazole 400mg orally, 12 hourly for 5 days

## Perineal postnatal care

**All perineal tears**

1. **Ask** about and **inspect** perineal healing / pain – each shift for 48 hrs
2. Postnatal care (HIPPS<sup>1</sup>):
  - **Hygiene**- keep clean and dry.
  - **Ice / cold packs**- first 48-72 hours for 10-20 minute intervals<sup>3</sup>
  - **Pelvic floor exercises**
  - **Pain relief**
  - **Support**- at all times. Give written and verbal information on perineal care
3. **Compression**- double pad and firm underwear until swelling resolved.
3. **Review** by Medical Officer if signs/symptoms of infection, wound breakdown, inadequate repair, or non-healing
4. **Dysuria** from labial grazes: Consider urinary alkaliniser, void in shower

**3<sup>rd</sup> & 4<sup>th</sup> degree tears** (See [3<sup>rd</sup>/4<sup>th</sup> Degree: Post Repair](#) section)**In addition** to the above:

1. **Infection prevention:** Antibiotics and good hygiene
2. **IDC:** Insert and to remain in situ for minimum 12 hours. Refer to Bladder Management guideline.
3. **Bowel care:** Laxatives, healthy diet & adequate fluid intake
4. **Referrals:** Physiotherapy (& consider dietitian)
5. **Comfort / care:** Encourage twice daily perineal showers
6. **Medications:** Avoid rectal suppositories & codeine
7. **Follow-up:**
  - At KEMH Perineal Care Clinic around 12 weeks (additional follow-up organised by the clinic if required)
  - Physio will organise a routine follow up at 6 weeks

Note: This flowchart represents minimum care & should be read in conjunction with the following full guideline and [disclaimer](#). Additional care should be individualised as needed.

## Key points

1. There is no evidence of benefit from adding either salt or anything else to bath water.<sup>1</sup>
2. Consider referral to physiotherapy.
3. Women shall be advised of the importance of perineal hygiene.<sup>1</sup>
4. Women should be informed that wound healing can be affected by age, obesity, medications, smoking, stress, anxiety and diet. Women should be educated on recognising the signs /symptoms of infection<sup>17</sup> and advised to seek medical care if any develop.<sup>18</sup>

## Procedure

1. All women should be asked whether they have any perineal pain or concerns about the healing process of any perineal / vulval wound<sup>1</sup> each shift for the initial 48 hours after birth (regardless of whether there is documented trauma).
2. Daily inspection is recommended due to sepsis being the leading cause of maternal mortality.<sup>18</sup> Severe pain and swelling to the perineal area or in the labia may be caused by haematoma and should be immediately reviewed by the obstetric team.<sup>1</sup>
3. Postnatal perineal care (H.I.P.P.S.)<sup>1</sup>:
  - **Hygiene-** keep the perineal area clean and dry<sup>1</sup>:
    - Encourage the woman to undertake strict perineal hygiene strategies to help reduce the risk of infection (e.g. hand washing before & after toileting/ changing sanitary pads and after nappy changes).<sup>17</sup>
    - They should be encouraged to wipe from the symphysis pubis towards the anus (front to back). The area should be washed with warm water and patted dry after showering, voiding and bowel movements. When clean pads are applied, care should be taken to avoid touching the central area, which will be in contact with the wound. Pads should be changed regularly.
  - **Ice-** first 48-72 hours<sup>1, 3</sup>
    - Topical cold therapy (e.g. cold pads / crushed ice in a wrapper) may be effective methods of pain relief for perineal pain.<sup>1</sup>
    - If cold therapy is used, it shall be applied to the perineum for 10-20 minutes<sup>3, 19</sup> and no more frequently than 2 hourly. Cold therapy is only of benefit in the initial 72 hours following birth.
  - **Pelvic floor exercises**<sup>18</sup>
    - Women who do pelvic floor exercises are less likely to report perineal pain, feelings of depression and incontinence at three months following birth<sup>1</sup>

- Explain and encourage gentle pelvic floor exercises. Refer woman to the WNHS patient brochures: [Physiotherapy After Childbirth book \(PDF, 7.7MB\)](#) and [Caring for Your Perineum](#) (PDF, 1.6MB).
- **Pain relief**<sup>1</sup>
  - If oral analgesia is required for perineal pain, paracetamol is the first line of treatment, followed by NSAID, unless contraindicated.<sup>1</sup> NSAIDs are effective for episiotomy / severe perineal trauma.<sup>1</sup> Rectal anti-inflammatory suppositories are effective in the first 24-48 hours but should be avoided in women with 3<sup>rd</sup> and 4<sup>th</sup> degree tears.
- **Support-** at all times<sup>1</sup>
  - The midwife shall assess the level of discomfort / pain the woman is experiencing and discuss / provide appropriate pain relief options / comfort measures<sup>1</sup>
  - Consider referral to a physiotherapist for positioning, education, therapeutic ultrasound\* and laser therapy.
  - Advise the woman to contact her GP following discharge if she experiences pain in the perineal area despite the wound having healed.
  - Provide verbal / [written information](#) (PDF 1.6MB) on perineal care- including infection prevention (e.g. good personal hygiene), signs/symptoms of infection and the importance of seeking medical advice early<sup>17</sup>

**Compression-** apply two pads stacked on top of each other and pulled up with firm underwear in first 24-48 hours or until swelling resolved.

**\*Note:** There is not enough evidence to evaluate the use of ultrasound on perineal pain.<sup>1</sup> However referral to physiotherapy may be considered since many women report improvement in perineal pain following ultrasound therapy.

4. Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing shall be evaluated urgently by the Medical Officer.
5. Healing can be assisted by keeping the area clean and dry and parting the labia to prevent adhesions/fusion. Labial grazes or lacerations that cause pain or stinging when voiding may be relieved by voiding in the shower, pouring warm water over the genitals during urination, or using a urinary alkaliniser (e.g. Ural) for the first few days, unless contraindicated. This is most effective when commenced immediately after birth / trauma.<sup>1</sup>

## Third and fourth degree tears: Post repair management

Provide care as outlined above for all tears ([Perineal Care- General](#) (HIPPS)). In addition:

1. **Bladder:** IDC for minimum of 12 hours. Consider to remain for 24 hours if other significant genital trauma or until severe swelling subsides. See Obstetrics and Gynaecology: [Bladder Management](#) guideline.
2. **Analgesia:**
  - Avoid codeine containing analgesics as they may lead to constipation.
  - Regular rectal analgesia should be avoided.<sup>14</sup>
3. **Bowel care:**
  - It is no longer necessary for women to remain in hospital until their bowels have opened.
  - Laxatives or stool softeners are advised for about 10 days<sup>5</sup> to reduce the incidence of postoperative straining and wound dehiscence.<sup>14</sup> It is also important that women remain well hydrated.<sup>14</sup>
  - Bulking agents should not be given routinely with laxatives. Using lactulose with ispaghula husk (e.g. Fybogel) may cause more frequent incontinence than lactulose alone.<sup>5</sup> Dietary fibre is important to prevent constipation which could place undue tension on the healing tissue or sutures. Encourage a healthy diet, with good hydration, and to report any concerns.<sup>1</sup>
4. **Antibiotics:** Post-operative antibiotics as per "[Antibiotics](#)" section above. The use of antibiotics is associated with less wound infection and wound dehiscence in third and fourth degree perineal tears.<sup>5</sup>
5. **Assess:**
  - Ask the woman whether she has any concerns about the healing process of the perineal wound, including perineal pain, discomfort, stinging, or offensive odour.<sup>1</sup> Daily inspection is recommended due to sepsis being the leading cause of maternal mortality. Severe pain and swelling to the perineal area or in the labia may be caused by haematoma and should be immediately reviewed by the obstetric team.
6. **Hygiene:**
  - Encourage the woman to shower at least twice daily for perineal comfort.<sup>14</sup>
  - Advise the woman to:
    - Keep the perineum clean and dry<sup>1</sup>: Change her sanitary pads 2-3 hourly

- Wash and dry her perineum after each void and bowel action
- Avoid salt baths, powders or steroid creams
- Maintain good personal hygiene during healing, a healthy diet and to report any concerns<sup>1</sup>.

**7. Referrals:**

- All women with third and fourth degree tears shall be referred for physiotherapy follow up.<sup>5, 14</sup>
- Consider referral to dietician.

**8. Provide information on pelvic floor muscle exercises.<sup>14</sup>**

**9. Advise the woman of:**

- The outcomes of anal sphincter injury
- Prognosis- that after EAS, 60-80% of women are asymptomatic at 12mths<sup>5</sup>
- Any signs of ongoing symptoms or consequences<sup>5</sup>
- Resuming sexual intercourse and dyspareunia management<sup>14</sup>
- Future management and the importance of follow-up<sup>5</sup>
- The effect of the injury on subsequent pregnancy management.<sup>14</sup> When planning future births it is recommended to seek advice on mode of delivery from an obstetrician.

**10. Follow up:**

- Prior to discharge all women who have sustained a third or fourth degree tear at WNHS should have a Perineal Care Clinic appointment made for 12 weeks postpartum<sup>5</sup> which includes a consultant obstetrician/ gynaecologist/ urogynaecologist, unless an earlier follow up is indicated.
  - See [WNHS website \(Health Professionals- Gynaecology Clinics- 'Perineal Care Clinic'\)](#) for an overview of this clinic and referral information [TBA]
- At the woman's follow up, if she is still experiencing incontinence or pain, then consider referral to a specialist gynaecologist or colorectal surgeon for endoanal ultrasonography and anorectal manometry<sup>14</sup> which will be addressed by the Perineal Clinic team.
- The Physiotherapy Department will also organise a follow up appointment at 6 weeks for these women.
- These appointments are in addition to the routine 6-week postnatal GP appointment.

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### Related legislation and policies

- OD 0657/16: [WA Health Consent to Treatment Policy](#) (2016)
- ACSQHC: [Clinical Care Standard](#): 'Third and Fourth Degree Perineal Tears'

### Related WNHS policies, procedures and guidelines

**WNHS Policy:** [Procedural Count: Management and Procedure](#) (available to WA Health staff through HealthPoint)

**WNHS Clinical Guidelines:**

- [Obstetrics and Gynaecology:](#)
  - [Bladder Management](#)
  - [Bowel Care](#)
  - [Female Genital Cutting / Mutilation](#)
  - [Infections in Obstetrics \(Intra-amniotic and Postpartum\): Diagnosis and Management;](#)
  - [Infections: Antibiotic Treatment for Vaginal Infections](#)
  - Postnatal Care
  - [Postpartum Complications](#) (available to WA Health employees through HealthPoint);
- Perioperative Services: [Surgical Count: Management and Procedure](#) (available to WA Health employees through HealthPoint)
- Pharmacy- [Adult Medication Guidelines: Diclofenac](#)
- Physiotherapy: [Third and Fourth Degree Tears, Physiotherapy Management](#) (available to WA Health employees through HealthPoint)

### Useful resources (including related forms)

**Perineal protection:** Women's Healthcare Australasia (WHA). [Perineal Tears](#) (external website): [The How to Guide: WHA CEC Perineal Protection Bundle](#) (external website, PDF, 9.2MB) Mitchell, ACT: WHA; 2019.

**WNHS Patient brochures:**

- [Caring for Your Perineum](#) (2015) (PDF, 1.6MB)
- [Physiotherapy after Childbirth](#) (2022) (PDF, 7.7MB)

- [Pregnancy, Birth and your Baby](#) Book (PDF, 7.7MB)
- WNHS website:**
- Physiotherapy Department: [‘I’m pregnant / Recently had a Baby’](#) (videos, resources)
- Forms:**
- MR 270 Partogram (includes section for Perineal Repair- Spontaneous Birth)
  - MR 275 Operative Vaginal Delivery and Perineal Repair

Keywords:	episiotomy, vaginal tear repair, perineal repair, vaginal suturing, perineum, perineal care, third degree tear, fourth degree tear, perineal tear, 3 <sup>rd</sup> degree, 4 <sup>th</sup> degree, perineal trauma, perineal pain, perineal discomfort, ice to perineum, HIPPS, ice to perineum, postnatal perineum care, perineum infiltration, prevent perineal tear, mediolateral		
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### Version history

Version number	Date	Summary
1	Sept 2020	First version. <b>History:</b> In Sept 2020 amalgamated four individual guidelines on perineal care dating from April 2003. <b>Supersedes:</b> <ol style="list-style-type: none"> <li>1. Episiotomy &amp; Infiltration of the Perineum (date last amended Feb 2015)</li> <li>2. Episiotomy / Genital Laceration: Suturing (dated Jan 2016)</li> <li>3. Perineal Care (dated July 2015)</li> <li>4. Perineal Trauma: Management of Third &amp; Fourth Degree (date last amended Dec 2014)</li> </ol>
1.1	June 2021	Minor amendment- New national clinical care standard has been

		released, so removed wording 'under development' where refers to the standard.
2	Oct 2022	<ul style="list-style-type: none"> <li>• New Perineal Care Clinic at WNHS. Changed 3<sup>rd</sup> and 4<sup>th</sup> degree tear sections to refer patients for postpartum review at this new clinic.</li> <li>• Compression added to list of perineal care measures</li> </ul>

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