University Hospitals Sussex
NHS Foundation Trust

Please note, IF DOCUMENT IS PRINTED, IT MAY BECOME OUT OF DATE

TRUST CLINICAL GUIDELINE

Perineal Trauma & Repair

Overview

This guideline aims to provide guidance on the OASI care bundle and benefits of perineal warming, on the recognition, classification and appropriate repair of perineal trauma, and the management of wound infection/dehiscence.

This guideline applies to all staff involved with assessment and repair of perineal trauma following childbirth. It covers:

- Assessing trauma
- Training and supervision
- Principles of repair
- OASI care bundle and perineal warming
- Suture material
- Suture technique
- Analgesia
- Aftercare
- Referral pathways
- Record keeping
- Perineal wound infection/dehiscence

Owner	Clinical Director
Author/Further information	Lorna Gisborne & Franciska Ambrus Pelvic Health Midwives
Guideline version	v1.0
Related policies	None
Related documents	**SRH&WH:** Care of Women and people in Labour, Operative Vaginal Birth, Female Genital Mutilation Shoulder Dystocia, Obstetric Haemorrhage, Postnatal Care. **PRH&RSCH:** Shoulder Dystocia, Obstetric Haemorrhage, Care of women/people in labour, Provision and schedule of postnatal care, Female Genital Mutilation, Assisted Vaginal Birth.
Standards	RCOG (2015) Green-top guideline 29 Management of 3rd and 4th Degree Tears The OASI2 study | RCOG Local SOP for Swabs, needle & instrument counts

	for invasive procedures in obstetric settings (outside of theatre) (Legacy West)
Superseded documents	CG1131 Perineal Trauma and Repair MP054 Perineal Trauma Repair
Review due	March 2027
Date uploaded	4th December 2024

Approval		
JOGG	Date approved	20th March 2024
Women & Children's Clinical Effectiveness Meeting	Date approved	18th April 2024
Medicines Governance Committee	Date approved	8th November 2024
Consultation		
Antimicrobial Stewardship Group	Date approved	7th October 2024
Ratification		
Clinical Document Approval Group	Date approved	29th November 2024

Table of Contents

Perineal Trauma & Repair

1.0 Introduction

This policy aims to provide guidance on the OASI care bundle and benefits of perineal warming, on the recognition, classification and appropriate repair of perineal trauma, and the management of wound infection/dehiscence.

2.0 Definitions and abbreviations used in this document

EAS External Anal Scanning	**EAUS** Endoanal Ultrasound Scanning
FGM Female genital mutilation	**MAU** Maternity Assessment Unit
MPP Manual Perineal Protection	**OASI** Obstetric Anal Sphincter Injury
RCOG Royal College of Obstetricians and Gynaecologists	**TNA** Training Needs Analysis
VBAC Vaginal birth after caesarean section	

3.0 Duties and responsibilities

All staff working in the Trust	• To access, read, understand and follow this guideline. • To use their professional judgement in application of this guideline.
Managers	• To ensure the guideline is reviewed three yearly and aligns with national standards. • To ensure the guideline is accessible to all relevant staff.

4.0 Background

In England, the reported rate of detected obstetric anal sphincter injury (OASI) among primiparous women and birthing people tripled over a ten-year period from 1.8% in 2000 to 5.9% in 2014. According to the 2019 clinical report from the National Maternity Perinatal Audit (NMPA), the overall incidence of detected OASI in Great Britain between 2016 and 2017 was 3.5% (range 1.6-7.5%). Although this increase is primarily associated with improved detection at the time of birth Gurol-Urganci, et al (2013), some tears continue to be undiagnosed, leading to a greater likelihood of developing anal and urinary incontinence symptoms, which can have a devastating impact on quality of life.

The main risk factor for anal incontinence amongst childbearing women and birthing people is OASI. A systematic review demonstrated a wide variation in the prevalence (2.2—36.7%) of anal incontinence in the short term, which can get worse over time.

Short-term complications of OASI include pain, bleeding and infection, which can result in urinary retention and constipation. These complications can lead to multiple attendances in hospital or community services. Long-term complications of OASI include anal incontinence (Faeces and Flatus), chronic pain, dyspareunia and urinary incontinence. The social, psychological, emotional consequences of associated anal incontinence is a hidden taboo which carries considerable morbidity Keighley et al (2016). In some circumstances, the trauma of sustaining an OASI and its complications affects subsequent births where a vaginal birth is forsaken for an elective caesarean, with associated additional costs.

Medico-legally, the total value of negligence claims relating to OASI during 2000 - 2010 was estimated to be £31.2 million. The leading cause is misdiagnosing a tear. The specific negligent acts related to failure to consider a caesarean section, failure to perform or extend an episiotomy, failure to diagnose the true extent and grade of the injury, inadequacy of repair and failure to perform a repair.

5.0 Prevention of obstetric anal sphincter injuries (OASI) and the OASI care bundle

There is not a clear predictive method for OASI, however the following risk factors have been shown to have a higher chance of sustaining OASI.

Risk factors of OASI:

- Asian Ethnicity birthing in high income countries only
- Nulliparity or first vaginal birth after caesarean birth
- Birth weight greater than 4kg
- Shoulder Dystocia
- Occipito-posterior position
- Prolonged second stage of labour
- Instrumental birth
- Previous OASI

5.1 Elements of the OASI Care Bundle

There are **four** key elements:

1. **Inform the pregnant woman or birthing person** about OASI and what steps can be taken to minimize their risk.
2. When indicated, **episiotomy** should be performed mediolaterally at a **60-degree angle at crowning.**
3. Documented use of **manual perineal protection (MPP)**:
    - For **spontaneous births**, manual protection should be used unless the woman or person objects, or their chosen position for birth doesn't allow MPP.
    - For **assisted births**, manual perineal protection should be used.
4. 4. Following birth, the **perineum should be examined** and any tears graded according to RCOG guidance. The examination should include a **per rectum (PR)** check even when the perineum appears intact and this should be documented on BadgerNet Maternity.

1. **Inform the woman or birthing person about OASI and what steps can be taken to minimise their risk**

   All pregnant women and birthing people should receive a notification from BadgerNet Maternity with a copy of the OASI Care Bundle information leaflet from 34 weeks onwards. Perineal massage is included in this leaflet and the benefits discussed. Perineal massage reduces OASI risk, and the need for episiotomy as well as improving wound healing and decreasing pain post repair Hajela (2021) Abedelkim (2020). If the OASI care bundle has been implemented fully, it can reduce the chances of OASI by 20% ref OASI2.

   If the pregnant woman or birthing person has not received information about the OASI Care Bundle before the start of their labour, the clinician should explain the care bundle at this time and address any questions or concerns the pregnant woman or birthing person may have. Few instances where it may not be possible to use MPP is when the pregnant woman or birthing person are labouring in water or, on a birthing stool (which itself can increase the risk of OASI) or if in a birthing position which has been adopted does not allow the midwife to place hands on the perineum.

   Perineal warming: Recommend to the pregnant woman or birthing person that a warm compress during the second stage of labour helps the perineal tissue to stretch and reduces perineal discomfort. It can also help increase the incidence of intact Perineum and reduces the incidence of perineal trauma. G Magona et al (2019).

The warm compress can be a swab or sanitary towel in warm tap water placed against the perineum, changed at regular intervals if soiled or cooled. The warm compresses should be used up until the point that MPP should be carried out to ensure adequate visualisation of the perineum.

2. **When indicated, episiotomy should be performed mediolaterally at a 60-degree angle at crowning**
There is little evidence to support the routine use of episiotomy for an unassisted birth; however, there is some evidence that episiotomy reduces the risk of OASI during instrumental birth. Episiotomy should never be a 'routine' intervention to reduce the risk of OASI and should only be carried out after clinical assessment of the fetal and maternal risks. The indication for an episiotomy should be recorded in the pregnant woman or birthing person's BadgerNet Maternity.

   Episiotomy is indicated in cases of fetal distress, instrumental birth. An episiotomy should be used for all term forceps and ventouse/kiwi births in nulliparous women and birthing people. In multiparous women and birthing people, an episiotomy should also be used for all term forceps births but may occasionally be omitted with a ventouse birth after considering and discussing the woman or birthing person's risk of sustaining an OASI. **Use MPP for all instrumental births, even after an episiotomy has been performed.**

   When a severe perineal tear is judged to be imminent, **feel digitally for remaining space/stretch and observe whether blood flow to the perineum appears significantly reduced (ie pallor of the stretched skin).**

   If an episiotomy is indicated, it should be performed at a **60-degree angle on the pregnant woman or birthing person's right as the baby's head is crowning.**

   Evidence suggests that this will reduce the risk of OASI. All midwives and obstetricians should be competent in performing this intervention. Studies have demonstrated that a significant proportion of 'mediolateral' episiotomies are performed at an inappropriately acute angle, perhaps due to the distorted anatomy at the time of crowning. **To facilitate achievement of the 60-degree angle, such as the use of scissors that indicate the correct episiotomy angle, have been shown to be effective** and may be considered.

   Please see Appendix 6 for a diagram of the correct procedure for 60-degree mediolateral episiotomy.

   Appropriate anaesthetic should be used prior to performing episiotomy. See section 9.3 for further information on dosage and administration.

   It is important that the clinician communicates the indication(s) for which an episiotomy is being considered with the pregnant woman or birthing person and gains their consent before performing the procedure.

3. **Documented use of manual perineal protection (MPP)**
Manual perineal protection (MPP) is a bimanual technique that requires support of the posterior fourchette with one hand and cupping of the fetal head with the other to prevent the head coming out with great force as it progresses at crowning (The Finnish Grip, see Appendix 1 for details on technique). It can be performed in most birthing positions that the pregnant woman or birthing person feels comfortable in. Support the pregnant woman or birthing person to adopt a position which decreases the chance of a deep tear such as all fours, kneeling or left lateral.

   Important principles are:

   a. Coaching the pregnant woman or birthing person to avoid sudden expulsive pushing.
   b. Maintaining gradual progress during the birth of the head.
   c. No undue downward traction during birth of the shoulders.
   d. Support the perineum throughout the whole birth.

   Great care should be taken during the birth of the shoulders and MPP should be continued as the shoulders are born. Depending on the woman or birthing person's position, the posterior shoulder may deliver first. The baby's body should be born following the direction of the curve of Carus using maternal or birthing parent effort and gentle axial traction, if needed, avoiding undue downward traction. Video link Manual perineal protection in left lateral

   Note: Anyone who experienced an OASI-type tear in a previous pregnancy, and is planning a vaginal birth, should ideally be supported at the time of birth by an experienced member of staff (band 6 or above) confident in the use of the OASI2 care bundle.

4. **Perineal examination, including a per rectum examination, carried out following all vaginal births**
Following birth, a systematic examination of the perineum should be carried out. It is recommended that a competent clinician assess the perineum following every vaginal birth. This assessment must include a rectal examination as recommended by NICE and should be carried out even when the perineum appears intact. This assessment should include an examination of the ano-rectum and vagina using the pill-rolling technique. The pill-rolling technique is to feel for the 'tone and bulk' of the sphincters. Note that the woman or birthing person's ability to squeeze is affected by whether they have an epidural, but the bulk can just feel thinner anteriorly if an OASI sustained ('thinner at 12 o clock' than at '9' and '3').

   Any tears should be classified according to the RCOG as stated in section 7.0 and documented on BadgerNet Maternity including a pictogram.

If a woman or birthing person declines examination of the perineum following vaginal birth, then the midwife must discuss fully the implications of undiagnosed perineal trauma especially 3rd of 4th degree tears. This discussion must be documented on BadgerNet Maternity. Please highlight, that an examination does not mean that suturing must take place, but it will give the woman or birthing person the tools to make an informed choice regarding suturing, once the extent of the trauma is identified.

6.0 Perineal repair and training

Qualified midwives and obstetric medical staff can perform perineal repair**.** Training for midwives and doctors is evidenced in the Training Needs Analysis (TNA).

7.0 Classification of perineal tears

Table 1. Classification of perineal trauma

Grade of trauma	Extent of injury
1st degree tear	Injury to perineal skin and/or vaginal mucosa
2nd degree tear	Injury to perineum involving perineal muscles but not involving the anal sphincter
3rd degree tear	Injury to perineum involving the anal sphincter complex
Grade 3a tear	Less than 50% of external anal sphincter (EAS) thickness torn
Grade 3b tear	More than 50% of EAS thickness torn
Grade 3c tear	Both EAS and internal anal sphincter (IAS) torn
4th degree tear	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa
Isolated rectal button hole tear	Isolated rectal and vaginal tear with intact EAS and IAS

Source: Sultan et al, 1993; Norton et al, 2002; Royal College of Obstetrics and Gynaecology, 2015

Buttonhole tear - Tear involves the anal mucosa with intact sphincter. If not recognised and adequately repaired, there is risk of ano-vaginal fistula.

8.0 Assessing perineal trauma

Assessment of perineal trauma should be carried out immediately after completion of the third stage (as above).

Before assessing genital trauma, healthcare professionals should:

- Explain to the woman or birthing person what they plan to do and why.
- Offer inhalational analgesia if required and regional anesthesia is not already being used.
- Ensure good lighting.
- Position the woman or birthing person so that they are comfortable and so that the genital structures can be seen clearly. This would normally be in the lithotomy position, in a homebirth, a position which facilitates the best angle for visualisation.

Correct diagnosis and treatment of third/fourth degree tears can improve outcomes for women and birthing people. A rectal examination following all vaginal births and before commencing the repair is recommended and should be offered and documented. This is recommended as obstetric anal sphincter injury or isolated rectal buttonhole tears are possible with an intact perineum. Gloves should be changed prior to and following the rectal examination.

If the midwife is in doubt about the extent of a tear, they should seek the advice of the labour ward co-ordinator, and the registrar will be asked to review if necessary. All skin tears that extend to the anal margin should be assessed by the obstetric registrar, to ensure that a third-degree tear is not missed. This review, including timing, must be documented on BadgerNet Maternity.

If there is any doubt in the grade of perineal trauma then the tear should be treated as a higher rather than a lower degree.

Any woman or birthing person who is suspected to have a third- or fourth-degree tear should have careful examination of the perineum by a senior obstetrician.

All perineal repairs should be performed as soon as possible to minimise the risk of infection and bleeding. The reason for any delay (more than 2 hours from the end of the 3rd stage) should be documented on BadgerNet Maternity. Repair of third- and fourth-degree tears should be performed in the operating theatre under regional or general anaesthesia, with good lighting and appropriate instruments. Repair of third-degree tears in the labour room may be performed in certain circumstances after discussion with a senior obstetrician (RCOG 2015) but this should not be the norm.

For women and birthing people who birth in water, any tears actively bleeding should be sutured as soon as possible. For tears not-actively bleeding, repair may be delayed for one hour if this is deemed appropriate.

9.0 First- and second-degree tears and episiotomies

Only tears confined to the skin may be left unsutured. Labial tears which are deep, bleeding or bilateral, should be sutured. There is no evidence to suggest that leaving second-degree tears unsutured is of any long-term benefit.

All tears where there has been a concern regarding previous female genital mutilation (FGM) must be examined and repaired by an experienced obstetric trainee or consultant owing to the possibility of distorted anatomy.

9.1 Preparing the woman or birthing person for the procedure.

Explain the procedure and gain verbal consent. Document accordingly.

If the woman or birthing person declines suturing, the reason should be clearly documented along with the advice given on BadgerNet Maternity. In anything more than a first-degree tear, the labour ward co-ordinator and/or obstetric registrar should see the woman or birthing person to discuss the benefits of suturing.

9.2 Equipment

A suture trolley/sterile area (if at home) should be prepared containing the following:

- Suture pack
- Sterile Gloves
- 20 ml syringe
- Green needle
- 2/0 rapidly absorbable suture (polyglactin suture such as Covidien Velosorb)
- 20ml 1% lidocaine
- Warm water
- Diclofenac 100mg suppository (if no contraindications)
- Swabs

9.3 Procedure preparation

Swabs, needles and instruments should be counted and verified by 2 health professionals (one must be the operator) and documented prior to commencement of the suturing (SRH & WH see P19005 LocSOP for Obstetric Procedural Counts.pdf).

The woman or birthing person should be made comfortable for suturing in an appropriate position; this may be in lithotomy or on the edge of the bed. The woman or birthing person could maintain skin-to-skin contact with their baby throughout the procedure, or once they feel comfortable, with support from their birthing partner. It is recommended that the partner stays in the room whilst suturing takes place in case the woman or birthing person wishes for the baby to be repositioned.

Once the woman or birthing person is ready, the perineal area should be cleaned with warm water, and sterile towels used to create a sterile field. Tampons should not be used outside of the theatres. No swabs should be inserted into the vagina.

If the woman or birthing person does not have an epidural, the area should then be infiltrated with 1% lidocaine. Up to 20mls 1% lidocaine total may be used (including for episiotomy). If an epidural is in situ, a top up may be required.

9.4 Suture material and technique

The use of rapidly absorbable synthetic material (polyglactin suture such as Covidien Velosorb) or Vicryl™ Rapide (Ethicon) for the repair of perineal trauma is associated with less perineal pain, lower analgesic use, lower risk of dehiscence and re-suturing when compared to PDS suture material.

The tensile strength of 2/0 polyglactin suture such as Covidien Velosorb or Vicryl™ Rapide (Ethicon) is reduced between 10-14 days and fully absorbed by 35-42 days.

The apex of the tear should be identified visually, and the first suture inserted 1 cm above this. The repair should then proceed with a continuous suture to the posterior vaginal wall. There is no need to knot this suture at the fourchette since a single continuous suture causes less pain than leaving a knot at the fourchette and starting again in the deep tissues.

The perineal muscle should then be repaired using a continuous suture. These sutures should be continued to the fourchette, bringing the muscles into apposition. Again, there is no need to tie the suture off here but continue directly with the skin stitch which minimises pain.

The skin should then be closed using a continuous subcuticular suture. Continuous subcuticular sutures are associated with less pain in the immediate post-partum period. The final knot should be an Aberdeen knot (because it requires very little suture material and hence minimises pain and scar formation) placed remotely from the fourchette since the fourchette is the most sensitive part. The skin suture should not be too tight or use sutures too close together, as this is associated with increasing the risk of dehiscence.

On completion of the repair the vagina should be checked for complete haemostasis then the tampon removed if used in theatre. To highlight a vaginal pack is in situ:

- An identifiable wristband stating 'Vaginal Pack inserted' is placed on the woman or birthing person's arm.

This wristband should be removed at the same time as the pack is removed.

A digital rectal examination should be done to ensure that no sutures have penetrated the rectal mucosa**.** If sutures are felt, refer the woman or birthing person for an obstetric review – do not remove the sutures prior to this review. If penetrating sutures are confirmed by the obstetrician, then the sutures will need removing before re-suturing.

Swabs, tampons, needles and instruments should be counted by 2 health professionals and documented at the end of the procedure (SRH & WH as per P19005 LocSOP for Obstetric Procedural Counts.pdf).

10.0 The management of labial and clitoral tears

If labial tears are bleeding, large or there is a likelihood of the labia fusing, repair with 3/0 Covidien Velosorb or Vicryl™ Rapide (Ethicon) is recommended. Good analgesia is required. The findings and management should be discussed with the woman or birthing person.

Interrupted sutures may give a better cosmetic appearance. Consideration should be given to the aesthetic result and the woman or birthing person's body image.

The area generally heals very well, so the minimum suturing required for haemostasis and tissue apposition should be done, with the use of Aberdeen knots to minimise size of knot and hence post-birth pain.

11.0 Third- and fourth-degree tears (OASI)

- Written consent must be obtained prior to the repair (note: when consenting for operative vaginal birth, include information regarding potential perineal trauma and repair).
- Both partner and baby should accompany the woman or birthing person to theatre in order to re-establish skin-to-skin contact as soon as possible and to offer the opportunity of an early breastfeed. The benefits of breast milk and uninterrupted skin-to-skin for the baby outweigh the historic practice of excluding partners and babies from theatre. The only exception is where there is a need of an emergency transfer due to haemorrhage or a general anaesthetic is required.
- The obstetric consultant should be notified of all 3rd degree tears, unless the senior specialist trainee has been assessed as competent to undertake the repair unsupervised.
- The obstetric consultant must attend for the repair of a 4th degree tear and repair must be in theatre.

- Third degree tears can be repaired in the labour room if this deemed acceptable by the senior obstetrician taking into account adequate analgesia, adequate lighting and acuity on labour ward: but this should not be the norm, as RCOG best practice is to repair all OASI in theatre.
- A definite attempt should be made to recognise the internal anal sphincter, so that this can be repaired as a separate layer, if necessary. The use of interrupted 3/0 PDS or 2/0 Polysorb (or equivalent) is recommended and should be repaired using the end-to-end technique with interrupted mattress sutures. The internal anal sphincter should not be repaired with an overlapping technique. Figure of 8 sutures should be avoided because they are haemostatic in nature and may cause tissue ischaemia (RCOG 2015).
- The use of 3/0 PDS is recommended in this unit for repair of the external anal sphincter. Use of fine suture size such as 3-0 PDS and 2-0 Polysorb (or equivalent) may cause less irritation and discomfort. The only randomised controlled trial comparing braided and monofilament sutures reported no significant difference in morbidity from anal incontinence, perineal pain or suture migration with 12 months follow-up.
- If the external anal sphincter is completely divided**,** an overlap technique should be considered. If the sphincter is not completely divided, there is insufficient evidence to recommend an overlap technique (which would require division of the remaining fibres), and an end-to-end repair should be used.
- When obstetric anal sphincter repairs are being performed, burying of surgical knots beneath the superficial perineal muscles is recommended to prevent knot migration to the skin. Women and birthing people should be warned of the possibility of knot migration to the perineal surface, with long-acting and non-absorbable suture materials.
- In the event of a 4th degree tear, the rectal wall should be repaired in 1 layer using 3-0 Polysorb or equivalent (RCOG 2015).
- At the end of the repair a rectal and vaginal examination should be performed to ensure that the anorectal mucosa is intact and that no sutures have penetrated the wall.
- 100 milligrams diclofenac should be administered rectally at the end of the procedure (contraindicated with asthma and with PPHs >1000ml). Rectal paracetamol (1 gram) can be used as an alternative if this has not been given in the last 4 hours and the woman or birthing person has not already exceeded the 4 grams daily dose.
- The obstetric consultant should repair or assist in the repair of fourth degree perineal tear and may discuss the management with a consultant colorectal surgeon. A combined approach to repair may be appropriate.
- All details regarding the repair should be clearly documented on BadgerNet Maternity by the obstetrician who performed the repair. The swab count, by two healthcare professionals, and estimated blood loss must be included.

- An Incident reporting (Datix) form must be completed, and the reference number documented on the OASI proforma on BadgerNet Maternity.

11.1 Antibiotics

A minimum of 1 dose prophylactic IV antibiotics should be given at the time of the procedure.

IV ANTIBIOTICS			
	Antibiotic	**Dose**	**Rate**
First line	Co-amoxiclav	1.2 grams	STAT
Penicillin allergy	Cefuroxime + Metronidazole	1.5 grams 500 milligrams	
Severe penicillin Allergy	Clindamycin + Gentamicin	900 milligrams 240 milligrams	
If known MRSA - add Teicoplanin			

If switch to oral antibiotics indicated:

ORAL ANTIBIOTICS			
	Antibiotic	**Dose**	**Rate**
First line	Co-amoxiclav	625 milligrams	TDS
Penicillin allergy	Cefalexin + Metronidazole*	500 milligrams 400 milligrams	TDS
Severe penicillin Allergy	Discuss with microbiology as clindamycin alone will not cover the gram-negative bacteria that could be implicated in these types of infections.		
• please note that metronidazole can taint the taste of breastmilk			

12.0 Post-repair for 3rd- and 4th- degree tears

- Foley catheter should be inserted and remain in situ for 24 hours until the patient is mobile.
- Consider a full blood count on day 1, depending on estimated blood loss and maternal condition.

- Regular analgesia must be prescribed (usually ibuprofen 400 milligrams TDS and paracetamol 1 gram QDS (unless contra-indications).
- High Fiber diet is recommended.
- Macrogols 1 Sachet taken 1-3 times a day dissolved in 125 millilitres of water. There is no evidence for the use of bulking agents (eg Fybogel) routinely following 3rd and 4th degree tears. Ideally the woman or birthing person should have a normal bowel movement before discharge from hospital, but if this doesn't happen bowel action should be monitored and documented at each visit.
- A senior clinician or Pelvic Health Midwife should see the woman or birthing person prior to discharge to explain the significance of the tear and follow up. The woman or birthing person should be given information regarding the nature of the injury and the importance of follow-up before they are discharged from hospital. The RCOG (2019) patient information leaflet 'Care of a third- or fourth-degree tear that occurred during childbirth (also known as obstetric anal sphincter injury – OASI' should be given.
- The woman or birthing person's GP is notified of the tear via the reports on BadgerNet Maternity, this relies on midwifery staff completing the birth documents and sending the report at the end of the process.
- Information on pelvic floor exercises should be provided. Signposting to the LMNS Sussex website for further information and videos on the correct way to perform pelvic floor exercises. Pelvic floor exercises are lifelong exercise to promote good pelvic health and prevent pelvic organ prolapse throughout a woman and person's life. The Fit for the Future booklet published by the Pelvic Obstetric and Gynaecological Physiotherapist should be given to the woman or birthing person prior to discharge or it is available via BadgerNet Maternity.

12.1 Referral and follow-up

The doctor performing the repair should complete all relevant documentation on BadgerNet Maternity - Episiotomy, Tears and Perineal Trauma section with a filled pictogram of the tear/episiotomy; as well as the Perineal Repair Note.

The health professional performing the OASI care bundle elements should complete the section under Episiotomy, Tear and Perineal Trauma section.

The midwife assigned to the woman or birthing person should check that this has been documented. They should complete the Perineal Tears Clinic referral form via BadgerNet Maternity (the clinic pathway is outlined in appendix 5) and Datix prior to transfer to the postnatal ward.

12.2 Prognosis and future births

- Women and birthing people should be advised that the prognosis following repair is good, with 60-80% asymptomatic at 12 months. Most women and people who remain symptomatic describe incontinence of flatus or faecal urgency.
- All women and birthing people who sustained an OASI in a previous pregnancy should be counselled about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal birth.
- All women and birthing people who sustained an OASI in a previous pregnancy should be advised that there is no evidence to support the role of prophylactic episiotomy in subsequent vaginal births.
- All women and birthing people who have sustained an OASI in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should have the opportunity to discuss elective caesarean birth.
- Women and birthing people with previous history of a 3rd or 4th degree tear require antenatal counselling by an obstetric consultant or senior registrar to agree a birth plan and discuss the risk of recurrence (the recurrence rate can be up to 20% depending on the extent of the previous tear). Post birth and prior to any repair, perineal assessment including a digital rectal examination should be carried out by a competent midwife who is confident of perineal trauma classification, to exclude repeat obstetric anal sphincter injury, regardless of perineal trauma sustained. Women and birthing people who birth at home, are recommended to have a systematic examination of the perineum including PR examination. If the attending midwife is confident of perineal trauma classification then there is no need to transfer in to hospital providing there is no evidence of OASI.
- The highest risk of recurrence of OASI is with subsequent forceps births. Accordingly, those caring for women and birthing people in labour who have had a previous OASI should make every attempt to avoid using the forceps to deliver the woman and birthing person unless absolutely necessary. If forceps are necessary the birth should be performed by an experienced operator, preferably a consultant.

13.0 Analgesia and laxatives

Administration of 100 milligrams diclofenac rectally immediately following any degree of perineal repair should be strongly considered (diclofenac is contraindicated with asthma and should not be given if there has been a PPH >1000ml). If diclofenac 100 milligrams PR has been administered, ibuprofen should not commence until 18 hours later.

IV paracetamol (1 gram) can be used as an alternative if there is a contraindication to diclofenac, if paracetamol has not been given in the last 4 hours and the woman or birthing person has not already exceeded the 4 grams daily dose.

Consider prescribing laxatives (Lactulose/macrogols) in all women and birthing people, especially women and birthing people on opiate based analgesia. All women and birthing people with 3/4th degree tears should be discharged with laxatives and encouraged to carry this on for the subsequent 4 weeks.

14.0 Record keeping

14.1 Documentation of consent, repair and post-care

All details regarding any repair (including the time in lithotomy) should be clearly documented on BadgerNet Maternity including a pictogram.

The swab count and estimated blood loss must be recorded. The swab count (both pre and post procedure) should be performed by two healthcare professionals (as per local guideline).

In a homebirth situation if only 1 midwife is present, they must carefully count and record the swabs. Information given regarding support following the repair should be documented within BadgerNet Maternity.

Following any perineal suturing the healthcare professional should offer perineal inspection at each postnatal review and document if the woman or birthing person declines. If the woman or birthing person declines, the importance of regular review should be explained.

Following readmission with perineal problems including infection, if still within the visiting period the community midwife must ensure the perineum is inspected at each visit as above. If they are no longer under community midwifery care, hospital staff caring for the woman or birthing person should inform the woman or birthing person's GP of any complications to ensure an effective aftercare plan is established.

14.2 Documentation for OASI Care Bundle purposes

All fields must be completed on BadgerNet Maternity including pictogram.

15.0 Perineal wound dehiscence (breakdown)

Perineal wound dehiscence occurs when healing of perineal trauma by the use of sutures has failed. The repaired perineum gapes and can become infected. The condition can result in significant physical and psychological problems if left untreated and so appropriate management is necessary to prevent this. There is currently insufficient evidence available to either support or refute secondary suturing for the management of broken-down perineal wounds following childbirth, but these should be assessed on an individual basis.

In the first instance, look for signs of infection. In case of suspected perineal wound infection in community (oozing, foul discharge, redness, pain), women and birthing people should be directed to their local Triage/MAU for swab, doctor review and broad-spectrum antibiotics with minimal delay and explained rationale. If still an in-patient, the wound should be swabbed, assessed by a doctor and broad-spectrum antibiotics prescribed.

Anti-inflammatory pain relief such as ibuprofen may help and is safe in breastfeeding. In the presence of active perineal infection, the wound cannot be re- sutured and will heal by secondary intention.

16.0 Incident reporting

For all women and birthing people who sustain a 3rd or 4th degree perineal tear, staff should complete a Datix incident form.

All women and birthing people seen either through the maternity or gynecology service following perineal repair dehiscence or with anal incontinence must have a Datix incident form completed in order to monitor outcomes.

Any postnatal readmissions, staff should complete a Datix incident form.

17.0 Monitoring

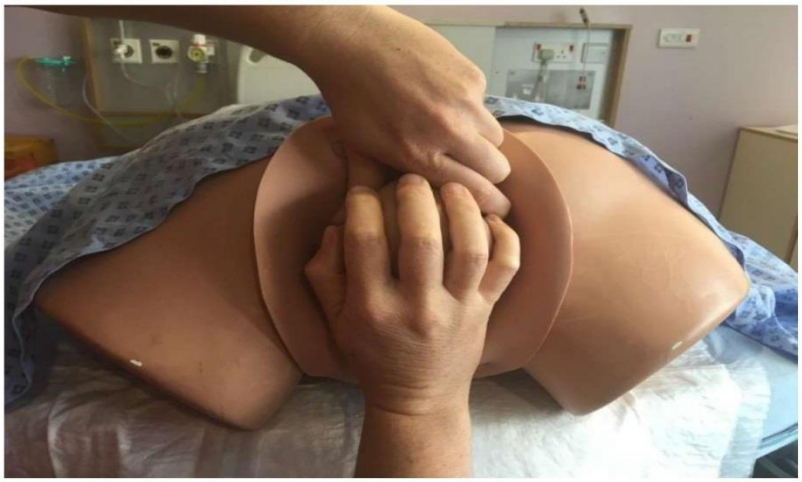
Organisations should audit the recognition of OASI and institute a guideline for repair and follow-up. Collected data should be audited against recommended/locally agreed standards:

- Incidence of OASI compared with reported incidence of less than 3% in the UK.
- 100% evidence of adequate documentation of systematic examination of the vagina, perineum and rectum prior to suturing of OASI.
- 100% of OASI repaired with documented evidence of type of analgesia, suture material, and method of repair and grade of operator.
- 100% of women and people with OASI receiving postoperative advice as per local guideline and follow-up appointment.
- 100% of doctors and midwives undertaking repair of OASI have attended recognised training courses.

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Incidence of 3rd or 4th degree tears	Case review	Patient Safety Midwives	On-going	Maternity Q&S Meeting

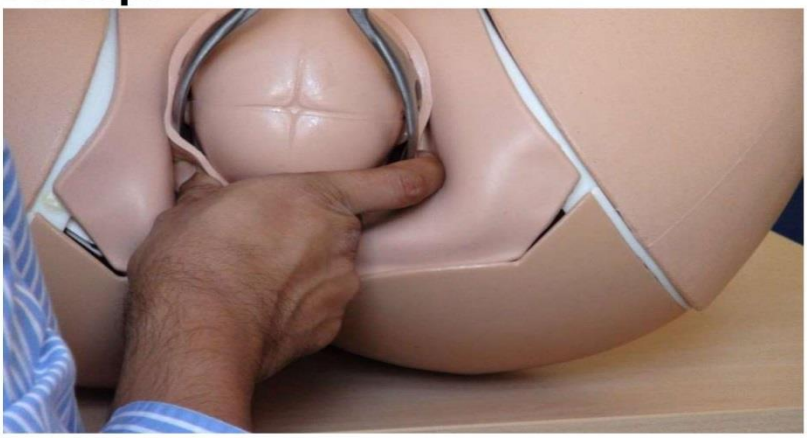
APPENDIX 1: IMAGES OF MANUAL PERINEAL PROTECTION (RCOG 2017)

'All fours' or hands and knees



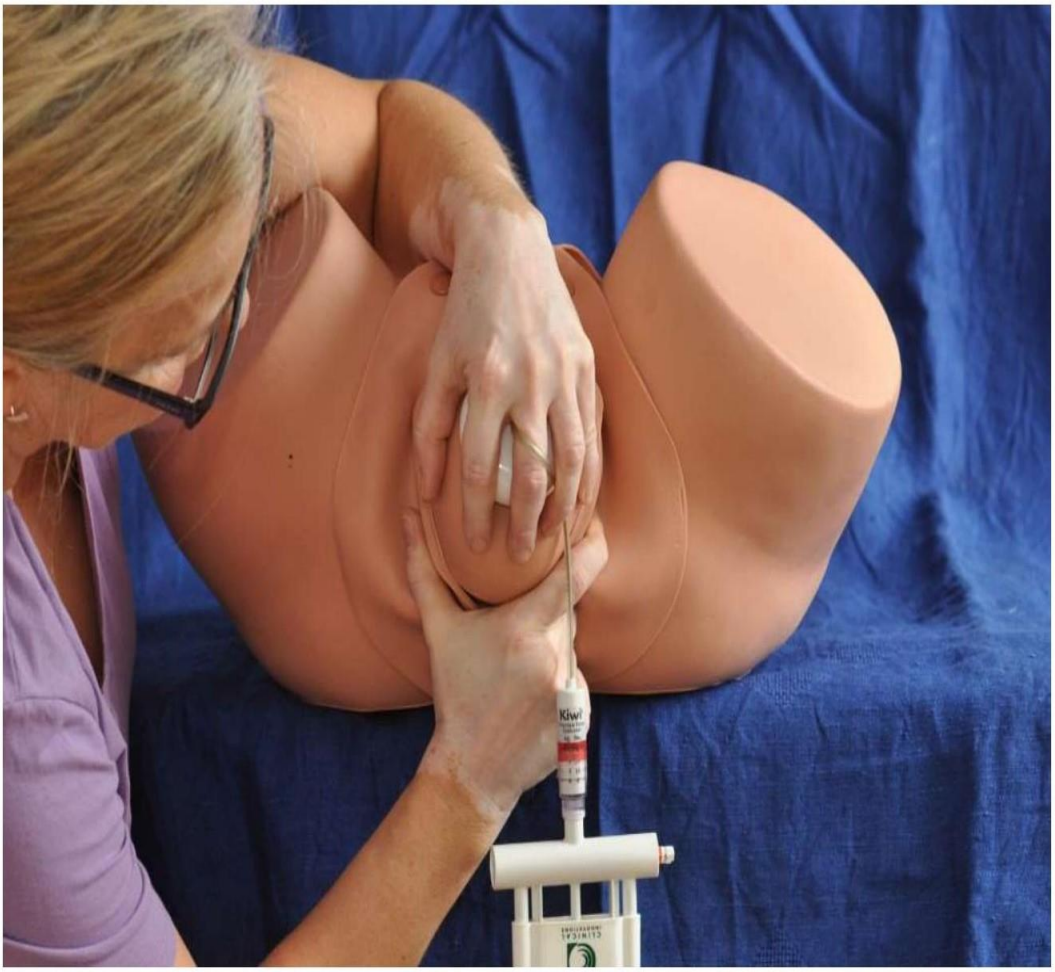
3 MPP in all fours position / Image courtesy of Guy's and St Thomas' NHS Foundation Trust

Forceps



4 MPP while using forceps / Image courtesy of Croydon University Hospitals NHS Trust.

Ventouse



5 MPP while using a ventouse / Image courtesy of Dr. Katariina Laine, University of Oslo, Norway.

Appendix 2: Repair of obstetric anal sphincter injury (OASI) proforma

Proforma can now be found on BadgerNet Maternity. The woman or birthing person's GP is notified of the tear via the reports on BadgerNet Maternity, this relies on midwifery staff completing the birth documents and sending the report at the end of the process.

Appendix 3: Information for women and birthing people (RCOG)

Click on link below to print leaflet for women and birthing people:

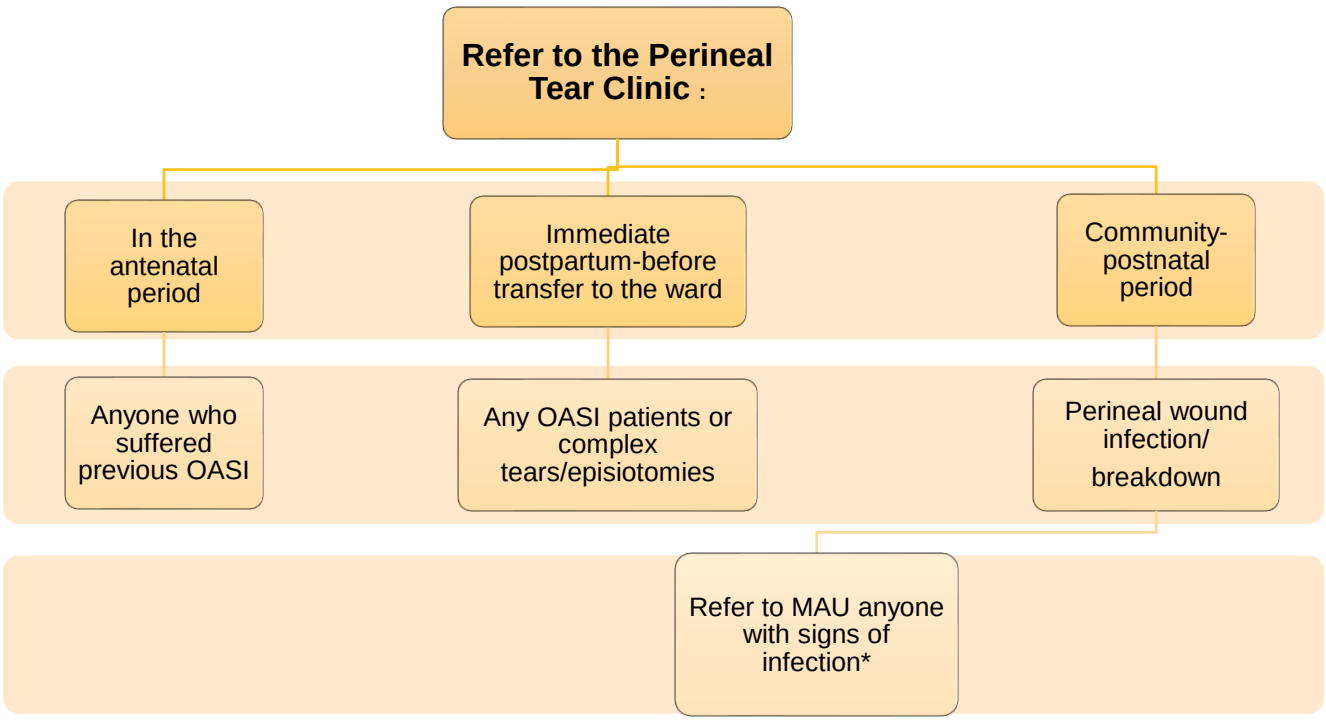
- Care of a third- or fourth-degree tear that occurred during childbirth (also known as obstetric anal sphincter injury – OASI) (RCOG, 2019)

Appendix 4: OASI care bundle information for women and birthing people

- Obstetric Anal Sphincter Injury Information for expectant mothers

Appendix 5: Referral to perineal tears clinic

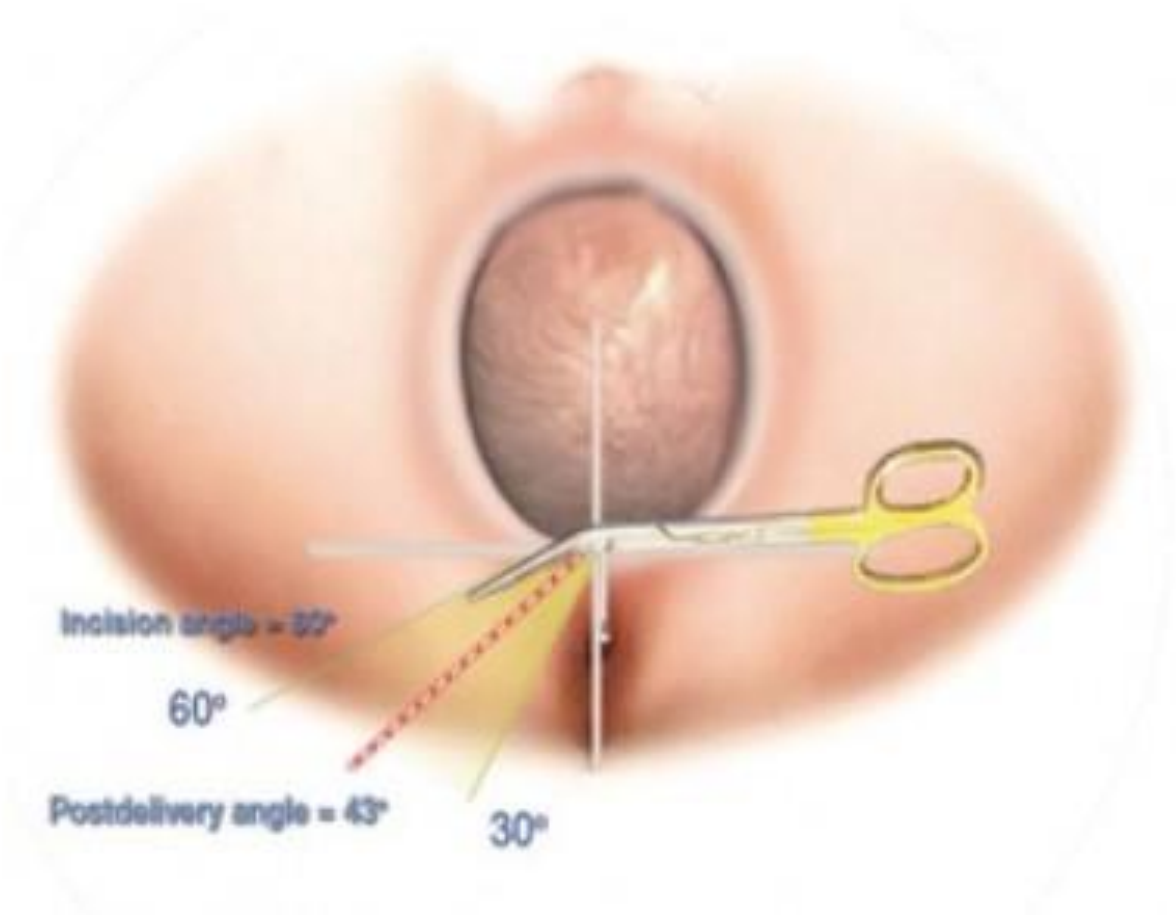
- All 3rd and 4th degree tears who birth at UH Sussex will need to be referred via BadgerNet Maternity to the Perineal Tears Clinic.
- The clinic pathway will consist of a telephone consultation 3 weeks post birth from a physiotherapist or pelvic health midwife. This telephone call will discuss recovery and pelvic floor exercises.
- At 6-8 weeks, a face-to-face consultation with a physiotherapist and/or pelvic health midwife will take place to assess perineal healing and to complete a pelvic floor assessment.
- 3 months post birth a face-to-face appointment will be offered with a consultant and pelvic health midwife or physiotherapist, to assess healing +/- endo anal scanning.



**MAU should see anyone with signs of sepsis/pain/foul/discharge/bleeding/gaping for swab, Dr review, +/- antibiotics after which refer for f/up – F2F in Perineal clinic.*

***Explain healing by secondary intention, consider extending visits to >10 days, email Pelvic Health Specialist Midwife if any concerns/advise needed.*

Appendix 6: 60-degree mediolateral episiotomy diagram (RCOG 2020)



Appendix 7: Guideline version control log

Change Log – Perineal Trauma & Repair

Version	Date	Author(s)	Comment
1.0	Mar 2024	Lorna Gisborne & Franciska Ambrus Pelvic Health Midwives	New UH Sussex Maternity guideline replacing: • CG1131 Perineal Trauma and Repair (Legacy West) • MP054 Perineal Trauma Repair (Legacy East)

Appendix 8: Due regard assessment tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Age	*No*	
	· Disability	*No*	
	· Gender (Sex)	*No*	
	· Gender Identity	*No*	
	· Marriage and civil partnership	*No*	
	· Pregnancy and maternity	*No*	
	· Race (ethnicity, nationality, colour)	*No*	
	· Religion or Belief	*No*	
	· Sexual orientation, including lesbian, gay and bisexual people	*No*	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*No*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*NA*	
4.	**Is the impact of the document likely to be negative?**	*No*	
5.	**If so, can the impact be avoided?**	*NA*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*NA*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*NA*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*Yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Appendix 9: Template dissemination, implementation and access plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	Comments
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives, obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual Communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development and clinical supervision as appropriate?	All new members of staff shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint

		Yes/No	Comments
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	N/A
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, safety noticeboards, Teams notifications and newsletter.

Appendix 10: Additional guidance and information

1. DeRidder, C.A., Berkowitz, C.D., Hicks, R.A. and Laskey, A.L., 2013. Subconjunctival hemorrhages in infants and children: a sign of nonaccidental trauma. Pediatric emergency care, 29(2), pp.222-226.
2. Li LH, Li N, Zhao JY, et al. Findings of perinatal ocular examination performed on 3573, healthy full-term newborns. Br J Ophthalmol. 2013;97(5):588–591
3. Spitzer, S.G., Luorno, J. and Noël, L.P., 2005. Isolated subconjunctival hemorrhages in nonaccidental trauma. *Journal of American Association for Pediatric Ophthalmology and Strabismus*, *9*(1), pp.53-56.
4. Parikh, Alomi O. et al "Prevalence and Causes of Subconjunctival Hemorrhage in Children." Pediatrics 146.1 MeetingAbstract (2020): 1-2. Web. 06 Jan. 2021.
5. Pan Sussex Child protection and safeguarding procedures
6. Royal College of Paediatrics and Child health Child Protection companion 2013, updated 2021.