BELIEVE MIDWIFERY SERVICES, LLC

TITLE: PERINEAL REPAIR  EFFECTIVE DATE: May, 2012

POLICY STATEMENT
The risk of perineal and vaginal injury during childbirth continues to affect the majority of women and approximately, 85%, will sustain some degree of trauma.

BLOOD BORNE PATHOGEN
EXPOSURE CATEGORY: I (Involves exposure to blood, body fluids, or tissues)

FUNCTION: Care of Clients

EQUIPMENT:
1. Sterile gloves
2. Needle holder (hemostat)
3. Metzenbaum scissors
4. Suture scissors
5. Forceps with teeth (Russian forceps)
6. Allis clamps
7. Lidocaine with 10mL syringe and appropriate needles
8. Suture kit including sterile drapes and gauze
9. Various sutures - preferred polyglactin 910 (Vicryl Rapide) which decrease the need for suture removal and result in decreased wound dehiscence and less postpartum perineal pain
10. Lighting

POINTS OF EMPHASIS:
There is limited evidence to inform clinical practice on how to prevent perineal trauma. There is some evidence that performing antenatal massage in primigravidas (only) can reduce the risk of trauma (Labrecque et al, 1999; Beckman and Garrett, 2006). However, this intervention must be carried out properly and be acceptable to women. Pelvic floor exercises are often recommended as a preventative treatment but evidence remains inconclusive to confirm or refute any beneficial claims.

During childbirth, continuous support, non-active pushing, a gentle birth and home birth may affect perineal outcome (Hodnett and Frederick, 2006). Birth position may also affect perineal outcome and the lateral position is reported to have increased rates of intact perineum (Shorten et al, 2002). Upright and hands and knees positions but not squatting are associated with a reduced risk of perineal trauma (Soong and Barnes, 2005).

Flexing the baby’s head and invasive perineal massage in labour does not reduce the risk of perineal trauma (Bedwell, 2006). The National Institute for Health and Clinical Excellence (NICE) (2007) have reported that hot and cold compresses do not reduce the risk of perineal trauma. However, it is reported that women find hot compresses soothing and ease pain during childbirth (Dahlen, 2007).

Up to 69% of women delivering vaginally will require suturing. The reported incidence of occult anal sphincter injuries (OASIS) varies from 1.7% in centres where mediolateral episiotomies are performed, up to 19% in centres practicing midline episiotomies (Stevenson, 2010).

The severity of a tear is classified by the severity of the perineal injury and what tissue levels are involved. First degree tear involves perineal skin layer only. Second degree tear involves posterior vaginal wall, subcutaneous fat, perineal skin layer, superficial muscles (bulbocavernous and transverse perinei) and deep muscle (pubococcygeus). Third degree tear involves the same structures as for the second degree tears and, in addition, the anal sphincter. Injuries involving the anal sphincter complex, both the external anal sphincter (EAS) and internal anal sphincter (IAS):
A fourth degree tear involves the anal sphincter complex (EAS and IAS) and anal epithelium.

The incident of more severe injury third and fourth tears has been estimated to be 0.5%-2.5% (Byrd et al, 2005). Vaginal birth is a major cause of anal incontinence among healthy women, potentially resulting in direct muscular and indirect neurologic damage to the anal sphincter (Swash, 1993; Kamm, 1994; Sultan and Kamm, 1997).

The rates of occult OASIS (sphincter damage not identified at delivery) were virtually unknown until Sultan et al (1993) used endoanal ultrasonography (EAUS) to demonstrate occult OASIS in 33% of women. Oberwalder et al (2003), in a meta-analysis of this and four further studies confirmed by EAUS found a 26.9% rate of OASIS in primiparous women and an 8.5% incidence of new injury in multiparous women, therefore estimating an incidence of 35.4% in multiparous women.

Authors (2002) have found that nearly 40% of all third degree tears had been missed on initial assessment. Additional authors (2002) found that 19% of tears classified as first or second degree involved anal sphincter injury. Another set of authors (2006) found that 26 midwives out of 30 (87%) missed OASIS, while 8 out of 29 physicians did the same. Even with recognition and immediate repair of OASIS, the prevalence of anal incontinence remains between 15% and 59% (Sultan and Thakar, 2002).

Suture technique and suture material can significantly contribute to the severity of perineal pain and discomfort. It has been reported that fewer women had pain at 10 days post delivery when a continuous suture technique was used for perineal repair compared with an interrupted suture technique. Removal of stitches was reported to be less when vicryl rapide suture material was used compared with vicryl (Kettle et al, 2002). NICE (2007) has recommended the use of a continuous subcuticular technique for suturing the skin layer.

There is some evidence that perineal repair workshops can be beneficial in promoting current evidence and best practice (Banks et al, 2006), as well as improve confidence. There is limited evidence regarding the benefit or harm of leaving perineal tears unsutured (Steen, 1998). Studies have reported conflicting findings in respect of the impact on perineal healing.

An episiotomy is performed when there is an indication to intervene, such as the fetus being in distress or when a forceps delivery is necessary. Evidence suggests a tear heals better (McGuiness, 1991).

‘...Perineal trauma can have long term social, psychological and physical health consequences for women. Perineal pain and discomfort may disrupt breastfeeding, family life and sexual relationships.’

PROCEDURE:

1. If any evidence of perineal trauma is identified on initial visual assessment following vaginal delivery, further systematic assessment might be improved by a rectal examination to exclude OASIS.
2. If perineal repair is carried out, rectal examination could be repeated to ensure that no suture material has been accidentally inserted through the rectal mucosa.
3. The procedure and reason for the examination must be explained and verbal consent obtained.
4. Ensure adequate analgesia.
5. Good lighting is essential.
6. Position the woman so that she is comfortable and the genitalia can be clearly visualized.
7. Observe if the perineal tear extends to the anal margin.
8. On visual examination the absence of anal puckering around the anterior aspect of the anus (between ‘9 and 3 o’clock) may suggest anal sphincter trauma.
9. Following visual examination, a vaginal examination should be performed to establish the full extent of the tear and identify the apex of the injury.
10. A rectal examination should then be performed to exclude anorectal tearing.
11. Severe perineal lacerations involving the anal sphincter complex, can be irrigated copiously to improve visualization and reduce the incidence of wound infection.
12. Because these lacerations are contaminated by stool, a single dose of a second- or third-generation cephalosporin may be given intravenously before the procedure is started.

13. Referral to a more experienced provider is recommended if the tear is beyond the Nurse Midwife’s skill. Recent studies have demonstrated at 20 to 50 percent incidence of anal incontinence or rectal urgency after repair of third-degree obstetric perineal lacerations. These injuries do not require immediate repair; hence, an inexperienced physician can delay the procedure for a few hours until appropriate support staff are available.

REFERENCES:

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