Episiotomy and perineal repair guideline (GL836)

Approval

<table>
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<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
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<tr>
<td>Maternity &amp; Children's Services Clinical Governance Committee</td>
<td>Chair, Maternity Clinical Governance Committee</td>
<td>3rd February 2017</td>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author, job title</th>
<th>Reason</th>
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<tr>
<td>6.0</td>
<td>September 2014</td>
<td>Pat Street (Consultant Obstetrician) / T Haxton (DAU Manager)</td>
<td>Reviewed</td>
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<td>6.1</td>
<td>Feb 2016</td>
<td>Christine Harding (Clinical Lead MW)</td>
<td>Pg 2 - Clarification of time to suture</td>
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<td>6.2</td>
<td>March 2016</td>
<td>Christine Bell (Snr midwife, DS)</td>
<td>Addition about recount made to Pg 3 &amp; 4 following a Never Event</td>
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<td>7.0</td>
<td>November 2016</td>
<td>C Harding, T Haxton</td>
<td>Reviewed Pg 1 Reference to GL1041 &amp; GL1042 added Pg 2 - bullet point added to Definitions Pg 3 – Procedure bullet points updated &amp; Analgesia bullet points updated Pg 4 - electronic record added &amp; link to Breastfeeding &amp; Codeine leaflet added Pg 5 – References updated</td>
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Please also refer to:
- Local Safety Standard for Invasive procedures (GL1041) FBS
- Local Safety Standard for Invasive procedures (GL1042) Repair of vaginal and/or perineal trauma in the birthing environment
Overview

Perineal trauma is one of the most common complications related to birth. It can occur spontaneously in the form of a perineal tear or secondary to an intervention such as an episiotomy or an assisted vaginal delivery, where possible repair of perineal should be undertaken within an hour of the delivery of the placenta, ideally by the person who conducted the delivery.

Episiotomy and 1st/2nd degree repairs can be performed by midwives. All other grades of perineal trauma must be repaired by an appropriately trained obstetrician. The relevant healthcare professionals should attend training in perineal/genital assessment and repair, and ensure that they maintain these skills as required in the Maternity Training Needs Analysis (CG360).

Definitions

- 1st degree tear – damage to the perineal/vaginal skin only with intact underlying perineal muscles
- 2nd degree tear – posterior vaginal wall, perineal skin and underlying muscle damaged
- 3rd degree tear – anal sphincter damage
- 4th degree tear – rectal mucosal damage

Rectal buttonhole tear – rectal mucosa with an intact anal sphincter complex. Refer to 3rd and 4th degree repair guidelines (GL926)

When non-suturing may be applicable:

- The evidence on leaving second-degree tears is currently inconclusive. Therefore second degree tears and unopposed vaginal edges should be sutured to improve healing and prevent mal-alignment. Minor tears can be left un-sutured (Gordon et al 1998, Lundquist M et al 2000, Fleming VE et al 2003, Leeman et al 2007).

Procedure:

Inform the woman about perineal damage as soon as possible particularly information regarding the degree of tear.
Assessment of the wound

- Examination of the degree of trauma should be carefully assessed with a good light source and adequate analgesia to identify the extent of any trauma, to include the structures involved, the apex of the wound and an assessment of bleeding.
- If genital trauma is identified a rectal examination should be recommended to exclude concealed trauma. [NICE 2014]
- Gain verbal consent to undertake the repair and record on the perineal repair sheet or electronic records (K2).
- If the suturing is delayed for any reason, inform the woman and record the reason on the perineal repair sheet or electronic record.
- In the home setting if it is not possible to adequately assess the trauma, transfer the woman (with her baby) to obstetric-led care (NICE 2014).

If the woman decides against suturing, advise on the healing process and document in the maternal health record. The woman should be referred to a more experienced healthcare professional if uncertainty exists as to the nature or extent of trauma sustained. The systematic assessment and its results should be fully documented, possibly pictorially.

Suturing Technique

- **Aseptic technique**: the suturing should be carried out as soon as possible after delivery and ideally within 1 hour of delivery of placenta, to minimise risk of infection and blood loss. Prior to commencing procedure remove the pack and gloves used at delivery, wash your hands and use a new suturing pack and new pair of gloves. Use an Octenalin solution to cleanse the perineum.
- **Analgesia**: Ensure the woman has adequate analgesia (up to 20ml Lignocaine 1%) can be administered by a midwife. If more analgesia is required, a medical practitioner must prescribe it. When teaching a student midwife the teaching midwife maintains responsibility for the administration of the Lignocaine under midwives administrations. Inhalational analgesia should be available and offered as appropriate.
- **Count**: swabs, needles and instruments before and after the repair and make a record in the notes or electronic record. *If another practitioner takes over during the procedure then a recount must take place.*
- **Position for Suturing**: the mother must be positioned appropriately for the repair. When using lithotomy poles the woman’s legs should be placed into and taken down from the lithotomy poles by two people in order to prevent musculo-skeletal
injury to the woman and staff. A good light source is essential to visualise genital structures.

- **Suturing technique:** The apex of the episiotomy or tear must be visualised, and secured firmly to achieve haemostasis. Correct anatomical alignment of the vagina, perineal body and skin must be achieved and the sutures should not be too small or too tight. Locked or non-locked continuous sutures may be used in opposing vaginal skin. The perineal skin may be left un-sutured, as in a two-stage technique (when using this technique the aim is to leave the skin edges no more than 0.5cm apart with the woman in the lithotomy position) or the edges opposed using subcuticular technique (Kettle et al 2007).

- **A vaginal examination & rectal examination** should be performed on completion of the repair to exclude sutures in the rectal mucosa; which can cause a fistula, and retained swabs. To ensure it is not too tight, the vagina should accept 2 fingers easily.

- **Sutures:** Polyglycolic acid (Vicryl Rapide) is the material of choice (Kettle and Johanson, 2001). At Royal Berkshire Hospital 2-0 Vicryl Rapide is used. 3-0 Vicryl Rapide, which has a smaller needle, may be used for labial tears.

- **Swabs:** must be ‘counted out’ in fives by the ‘repairer’ to a witness, collected in a separate bucket during the procedure and ‘counted in’ to a witness after the repair is completed. A signature is required to confirm this has happened. *If another practitioner takes over during the procedure then a recount must take place.*

- **3rd/4th degree tears or extensive tears and any doubt about the repair must be referred to an appropriately trained obstetrician. Refer to 3rd and 4th degree repair guidelines (GL926)*

- **Advice** on the after care should be given especially hygiene, analgesia and pelvic floor exercises. Give information leaflet on ‘Tears and Stitches’ and record that this has been done on the perineal repair sheet or electronic record.

- **Post-operative pain relief:** rectal Diclofenac 100mg followed by Ibuprofen 200-400mg up to 4 times daily, no sooner than 16hrs (in suitable women) and Paracetamol 1g 6hrly. Oral codeine 30mg up to 3 times daily, for those women unable to take NSAIDs). Women given codeine and breastfeeding or planning to breast feed should be given the Maternity information leaflet Breastfeeding and Codeine.
**Record keeping**

Enter all discussions and procedure notes in ‘Repair of Perineal Trauma’ sheet in hospital notes or on electronic records (NMC 2015).

In all cases where the woman has required suturing the wound should be visualised at each postnatal visit to detect early signs of breakdown and infection and recorded in the postnatal health record.

In the event of minor breakdown or infection that is not resolved with the first course of antibiotics the woman should be referred to the Day Assessment Unit and assessed by a senior clinician. The perineal assessment tool should be commenced and a clinical incident form completed. This will be monitored and reported monthly and any trends identified at the earliest opportunity. (See MDT wound assessment tool and care plan)

**Auditable standards:**

1. All perineal tears where suturing is required, suturing will commence within one hour of delivery of the placenta.
2. All 1st, 2nd degree tears, episiotomies and labial graces can be repaired by a midwife that has completed perineal repair training or by a trained obstetrician. All 3rd and 4th degree tears will be repaired by an obstetrician that has undergone “3rd and 4th degree tear training.
3. Consent will be sought and documented for all types of perineal trauma repair. This will be documented in the “suturing” documentation page
4. In all cases where perineal trauma is sustained the form “Examination of the vagina, labia & perineum” to ensure systematic assessment of the trauma sustained and “suturing”, or “perineal repair details” will be fully completed (as applicable).
5. Suturing will be offered for all second degree tears episiotomies, 3rd and 4th degree tears. For minor tears such as labial lacerations with opposed edges or first degree tears non-suturing may be applicable. The routine suturing material and the method of repair will be as stated in the guideline.
6. All women undergoing perineal trauma repair will receive the PIL “tears and stitches” for non-third/fourth degree tears or “perineal trauma – management of third and fourth degree tears” for third/fourth degree tears. Caring for sutures will be discussed for all women that have undergone perineal repair. This will be documented in the maternal health care record.
References:


9. RCOG (2015)Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29)