Guideline for the Repair of Perineal Lacerations

Perineal or genital trauma caused by either tearing or episiotomy is defined as follows:-

- First degree – injury to skin only
- Second degree – injury to the perineal muscles but not the anal sphincter
- Third degree- injury to the perineum involving the anal sphincter complex
    - 3a – less than 50% of the external anal sphincter thickness torn
    - 3b – more than 50% of external anal sphincter thickness torn
    - 3c- internal anal sphincter torn
- Fourth degree – injury to the perineum involving the anal sphincter complex (external and internal anal sphincter) and anal epithelium

This guideline is for First and Second degree tear repair.

A skilled heath care professions should only undertake repair of the perineum following delivery.[1] However, it is acknowledged that this procedure may be performed by a health care professional, who requires to be supervised until competence is achieved. If genital trauma is identified following birth the woman should be advised of the proposed procedure and verbal consent should always be obtained. The initial assessment should be carried out both sensitively and gently immediately following birth.

The woman should be in a position that ensures adequate visual assessment of the degree of trauma. This position should only be maintained for as long as is necessary for the systematic assessment and repair of sustained trauma.

If the woman is within the hospital environment she would usually be placed in lithotomy position.

If the woman is delivered at home the position would require modification along with an adequate light source to ensure systematic assessment of the perineal trauma.

Equipment Required

- Perineal repair pack and associated sterile drapes
- Suture material – Vicryl Rapide 2/0
- X Ray detectable swabs
- Non-alcohol containing cleaning fluid
- Local anaesthetic – Lidocaine 1% 20mls = 200mgs
- Adequate light source
- Clinical waste bag
- Clear plastic bag for swab, tampon and red tag disposal

Once the woman is positioned appropriately the vulva area should be cleansed and sterile drapes arranged as required. Following an initial swab, sharp and instrument count by the clinician and the assistant, the procedure is then undertaken using an aseptic technique.

It is imperative that all swabs, instruments and sharps are counted at the start of the procedure and no assumptions should be made that the starting count is standard. If any additional items are required during the repair then these must be included in the count, and accounted for at the end of the procedure. This must then be documented in badger by the person performing the repair and countersigned by the other person involved in checking.

A further systematic assessment of the perineum and genital tract should be carried out prior to commencing repair. This should include

- Ensuring the woman is comfortable and local analgesia is effective
- Further explanation of what the health care professional plans to do and why
- Perform visual assessment of the extent of the perineal trauma to include the structures involved, the apex of the injury and assessment of bleeding
- A gentle rectal examination to assess whether there has been any damage to the external or internal anal sphincter and to ensure no sutures were inadvertently placed through the rectal mucosa.

Performing Perineal Repair

If repair is following an operative vaginal delivery prophylactic antibiotics are now recommended as per "Antibiotics after Operative Vaginal Delivery for Prevention of Sepsis" guideline (NEW 2020)

1. Unless an effective epidural or spinal anaesthetic is in place, the perineum should be infiltrated with lidocaine 1%. (Refer to Patient Group Directive for dosage details). Confirm the local anaesthesia is working before commencing suturing.

2. Insert the vaginal tampon **only if necessary**, to provide a clearer view of the area to be sutured. The tampon provided is inserted into the vagina above the level of the apex of the tear and the tab clipped. It is acknowledged that on occasions the tampon may be insufficient in arresting bleeding and allowing the operator a clear view of the area to be repaired. If on these occasions it is necessary to place a swab within the vagina, both the operator and assistant should take a note of this and the swab accounted for in the final swab count. **Only x-ray detectable swabs must be used.**

3. Identify the apex of the wound. Place the first stitch approximately 0.5cm beyond the apex to allow for haemostasis of any small vessels, which may have retracted beyond this point.

4. Insert the anchoring suture above the apex. Repair the vaginal wall using a continuous stitch with approximately 0.5cm between each bite.

5. Carry out the repair from apex to the introitus, ensuring sutures are not placed in the hymenal remnants.

6. At this point place the needle behind the exit point of the last stitch. Sweep it under the fourchette bringing the suture material out into the perineal muscle.

7. Repair the perineal muscles in one or two layers with the same continuous stitch. It is important to oppose the muscle edges carefully and leave no dead space. Usually three or four stitches are all that is required in any one layer.

8. Using a side-to-side technique when suturing subcutaneous (1/2cm bites), continue until the proximal end of the wound is reached. There will be up to a 1/2cm gap between the skin edges.

9. Sweep the needle behind the fourchette back into the vagina. Pick up a small amount of vaginal tissue to tie off the stitch and cut (the knot is tucked into the vagina to minimise discomfort)

10. Check haemostasis has been achieved. NB – an excessive amount of sutures may well cause severe discomfort in the peurperium and beyond. Only carry out the required amount of suturing to achieve haemostasis.

11. Remove the vaginal pack, if used, and account for all swabs and needles. All counts of instruments, swabs and needles must be performed by two people and each person must sign as complete in the relevant documentation on badger.

12. Perform a vaginal examination and a rectal examination to confirm that no stitch has penetrated the rectal mucosa.

13. Remove woman's legs from lithotomy position.

14. Explain the extent of trauma and advise woman re hygiene and pain relief associated with perineal trauma.

15. Two health care professionals must check swabs, instruments and needles. Swabs, tampon and red tag must be placed into a clear bag which is then placed into an orange clinical waste bag for disposal.

16. Document full perineal procedure and swab, instrument, sharp count within electronic notes.

Procedure to be undertaken in the event of an incomplete swab, sharp or instrument count at the end of the perineal repair – Comply with Standard Operating Procedure - Instrument, Sharps and Accountable Items Count Outside Theatre in the Maternity Setting

It is imperative that all swabs, instruments and sharps are counted at the start of the procedure and no assumptions should be made that the starting count is standard.

- In the event of the above occurring the clinician and the assistant must repeat the check taking account of all used and unused items.
- The digital vaginal examination should be repeated following gaining consent and providing a full explanation to the patient
- No material must be removed from the LDRP room or theatre
- If there is still a discrepancy in the count, midwives and SHO's should inform the unit coordinator and obstetric registrar of the incident
- A DATIX should be completed
- An X-ray must be arranged and a full explanation given to the patient and her partner

In the event of an incomplete count and no evidence of retained material reported on x-ray, details must be recorded within the patient's case record, the consultant informed and a Datix report completed.

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4 Kettle C, Johanson RB. Continuous versus interrupted sutures for perineal repair. *Cochrane Database System Review* 2003; CD000947

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6 NHSL SOP Swab, Instrument, Sharps and Accountable Items Count Outside Theatre in the Maternity Setting

NHSL guideline Antibiotics after Operative Vaginal Delivery for Prevention of Sepsis 2023