PERINEAL OR GENITAL TRACT TRAUMA FOLLOWING CHILDBIRTH - CLINICAL GUIDELINE FOR IDENTIFICATION AND MANAGEMENT

1. Aim/Purpose of this Guideline
1.1. This gives guidance to obstetricians, anaesthetists and midwives on the identification and management of perineal or genital tract trauma following childbirth.

2. The Guidance
2.1. Guideline for the management of perineal or genital trauma following childbirth.
Following vaginal birth an initial examination for perineal and genital trauma should be carried out as soon as possible. This should be done once the general wellbeing of the mother and baby has been established, it should not however, interfere with the mother and baby skin to skin contact.

2.2. Initial assessment
- Explain to the woman what the assessment will entail and obtain verbal consent
- Offer inhalation analgesia
- Ensure good lighting
- Ensure the woman is in a suitable position to visualize the genital structures
- Visual assessment of the extent of perineal trauma to include the structures involved the apex of the injury, and an assessment of any bleeding
- If trauma is identified perform a rectal examination to assess whether there is any damage to the external or internal anal sphincter

2.3. Identification of the type of trauma
- 1st degree involves injury to the skin only
- 2nd degree involves injury to the perineal muscles but not the anal sphincter
- 3rd degree involves injury to the perineum involving the anal sphincter
  - 3a: less than 50% of the external anal sphincter thickness torn
  - 3b: more than 50% of the external anal sphincter thickness torn
  - 3c: both the external anal sphincter and the internal anal sphincter torn
- 4th degree involves injury to the perineum involving sphincter complex (external and internal anal sphincter) and anal epithelium.

2.4. Management of 1st degree tears
Suturing should be advised unless the skin edges are well apposed and there is no bleeding from the trauma site. If suturing is undertaken it should be as per the management of a 2nd degree tear.

2.5. Management of 2nd degree tears
Suturing to the muscles should be advised to improve healing. Following suturing of the muscle, if the skin edges are well apposed and there is no bleeding from the...
trauma site, the woman can opt to not have the skin sutured.

- Verbal consent should be obtained from the women and documented on the suturing proforma
- Examination of the vagina and rectum prior to suturing to ensure the correct grade of perineal tear (new 2016)
- The repair should take place using an aseptic technique
- Equipment should be checked and swabs and needles counted before and after the procedure and the findings documented
- Ensure good lighting
- A skilled midwife or obstetrician (or one undergoing instruction from a skilled midwife or obstetrician) should undertake the repair
- Confirm with the woman that she has adequate pain relief in the form of either local anaesthetic of up to 20mls of 1% lidocaine or under regional anaesthesia, unless there is a contraindication (NEW 2016)
- Vicryl rapide 2.0 should be the suture material of choice
- Visualize and identify the apex of the wound
- A continuous suturing technique should be used to oppose each layer
- Aim for good approximation of tissue, with alignment of the forchette and skin with a continuous subcuticular suture. Aim for a good cosmetic result
- Confirm haemostasis
- Examination of the vagina and rectum post suturing to ensure that suture material has not accidentally penetrated the rectal mucosa
- Offer rectal non-steroidal anti-inflammatory analgesia, Voltarol 100mg, unless there is a contraindication e.g. asthma
- Advice should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic floor exercises

2.6. Management of 3rd and 4th degree tears
Following the initial examination, if trauma to the anal sphincter is confirmed or suspected an experienced practitioner trained in the recognition and management of complex perineal tears should be asked to make a further assessment.

If a 3rd/4th degree tear is confirmed:

- Repair should take place by an experienced, appropriately trained obstetrician (at either middle grade or Consultant level)
- Repair should be conducted in an operating theatre under regional or general anaesthesia with appropriate instruments and an assistant
- Written consent should be obtained from the woman
- The ‘WHO’ obstetric check list must be completed in theatre
- Equipment should be checked and swabs and needles counted before and after the procedure and the findings documented
- The sphincter may be repaired with either an end to end or an overlapping technique depending on the experience of the surgeon. There is some evidence however that the overlapping technique has some benefit to the end to end technique. The ends of the sphincter should be brought together without any tension

The external anal sphincter should be repaired separately from the internal anal sphincter

- PDS (3.0 PDS) should be used to repair external and internal anal sphincter (NEW 2016)
• Surgical knots should be buried beneath the superficial perineal muscles otherwise there is the risk of knot migration. Women should be advised of this particularly if PDS is used
• Women should be given IV Ceftriaxone and Metronidazole at the time of repair in theatre and should be followed by oral Cephalexin 500mgs TDS and Metronidazole 400mgs TDS for 5 days, unless there is a contraindication
• An indwelling catheter should be left insitu, for at least 12 hours, if a spinal or full epidural top up is given
• Women should also be prescribed 10 days of Fybogel and Lactulose
• All women with a 3rd or 4th degree tear should be offered a physiotherapy review on the post natal ward and instructed on pelvic floor exercises
• All women should be offered an appointment in the consultant clinic 6 weeks postnatally, either by making a routine antenatal clinic appointment or via a letterIf a woman complains of faecal incontinence at follow-up, a referral to Perineal clinic to be made

NB: If the 3rd degree tear is superficial and there is adequate lighting and analgesia then it is appropriate, after discussion with the woman, for the repair to be undertaken in the room. In these circumstances it is appropriate to obtain verbal consent only. However, it must be ensured that the woman receives an initial dose of IV antibiotics, oral antibiotics, appropriate laxatives and a post natal follow up.

2.7. Documentation
The RCH suturing proforma must be completed, for all types of repairs, and filed chronologically in the woman’s health records. (Appendix 3)

2.8. Women who return to hospital due to a problem with a perineal or genital trauma suturing.
An electronic incident form (datix) should be completed for any woman who returns to hospital, for a non-routine appointment, with problems related to perineal or genital tract trauma. These woman’s notes will be reviewed to ensure that correct procedures were followed at the time of suturing and any deficiencies identified and feedback to the person performing the repair.

2.9. Suturing competence
A midwife who has not previously undertaken any formal training in perineal and genital trauma repair should attend a formal in-house training session on suturing. The midwife may then undertake suturing under the supervision of a midwife already experienced in perineal and genital trauma suturing. All midwives who are already experienced in suturing will attend a formal in- house training session at least every 2 years.

Doctors in training. Competencies will be assessed as part of the structured training programme and assessment. For doctors not on a training programme, supervision by a senior obstetrician will be required and competency forms completed. Once they have achieved the level of independent practice supervision will no longer be required.

3. Monitoring compliance and effectiveness

| Element to be | The audit will take into account record keeping by obstetric and |

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| monitored                        | anaesthetic staff and midwives.  
|                                 | • The results will be inputted onto an excel spreadsheet  
|                                 | • The audit will be registered with the Trust’s audit department  
| Lead                            | Maternity Risk Management Midwife  
| Tool                            | **All suturing**  
|                                 | • Was a suturing proforma completed and filed in the woman’s notes  
|                                 | • Is it documented that information regarding support following the tear, was given  
|                                 | **For 1st/2nd degree tears**  
|                                 | • Was the repair of a 1st/2nd degree tear performed by an appropriately trained midwife/obstetrician  
|                                 | • Was verbal consent obtained for the 1st/2nd degree tear repair  
|                                 | **For 3rd/4th degree tears:**  
|                                 | • Was the repair of a 3rd/4th degree tear performed by an experienced, appropriately trained obstetrician (middle grade or Consultant level)  
|                                 | • Was written consent obtained for 3rd/4th degree tears  
|                                 | • Was the repair of the 3rd/4th degree tear undertaken in the operating theatre  
|                                 | • Did the woman receive 1 dose of IV antibiotics and a 5 day course of oral antibiotics  
|                                 | • Did the woman receive a follow up at 6 weeks post delivery  
|                                 | • Did the woman receive an appropriate laxative  
| Frequency                       | • This audit will be added to the rolling audit programme and will take place every three years  
|                                 | • 1% of all women who have had repair of genital tract trauma  
| Reporting arrangements          | • A formal report of the results will be received annually at the Maternity Risk Management Forum and Maternity Clinical Audit Forum as per the audit plan  
|                                 | • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Maternity Risk Management meeting and Maternity Clinical Audit Forum and an action plan agreed.  
| Acting on recommendations and Lead(s) | • Any deficiencies identified on the annual report will be discussed at the Maternity Risk Management Forum and Maternity Clinical Audit Forum and an action plan developed  
|                                 | • Action leads will be identified and a time frame for the actions to be completed  
|                                 | • The action plan will be monitored by the Maternity Risk Management Forum and Maternity Clinical Audit Forum until all actions complete  
| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within an agreed time frame.  
|                                 | • A lead member of the Maternity Risk Management Forum will be identified to take each change forward where appropriate  

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4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>PERINEAL OR GENITAL TRACT TRAUMA FOLLOWING CHILDBIRTH – CLINICAL GUIDELINE FOR IDENTIFICATION AND MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>15TH December 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>15th December 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>15th December 2019</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Farah Lone  
Consultant Obstetrician  
Obs and Gynae Directorate |
| Contact details: | 01872 252729 |
| Brief summary of contents | This gives guidance to obstetricians, anaesthetists and midwives on the identification and management of perineal or genital tract trauma following childbirth. |
| Suggested Keywords: | Perineal, repair, perineum, suturing, 3rd/4th, 1st/2nd degree tears, perineal, 1st, 2nd, 3rd, 4th, Vicryl, |
| Target Audience | RCHT | PCT | CFT |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 1st December 2016 |
| This document replaces (exact title of previous version): | Clinical Guideline for the Identification and Management of Perineal or Genital Tract Trauma Following Childbirth |
| Approval route (names of committees)/consultation: | Maternity Guideline Group  
Obs and Gynae Directorate |
| Divisional Manager confirming approval processes | Head of Midwifery |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet | ✓ Intranet Only |
## Related Documents:

- Royal College of Obstetricians and Gynaecologists (March 2007) Management of third and fourth degree perineal tears. Green top Clinical guideline number 29 RCOG. London


## Training Need Identified?

- Suturing competence
- A midwife who has not previously undertaken any formal training in perineal and genital trauma repair should attend a formal in-house training session on suturing.
- The midwife may then undertake suturing under the supervision of a midwife already experienced in perineal and genital trauma suturing.
- All midwives who are already experienced in suturing will attend a formal in-house training session at least every 2 years.
- Doctors in training. Competencies will be assessed as part of the structured training programme and assessment.
- Doctors not on a training programme, supervision by a senior obstetrician will be required and competency forms completed. Once they have achieved the level of independent practice supervision will no longer be required.

## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>Oct 2009</td>
<td>1.0</td>
<td>Initial version</td>
<td>Karen Watkins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant obstetrician</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Description</td>
<td>Updated by</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>May 2011</td>
<td>1.1</td>
<td>Updated to include compliance monitoring</td>
<td>Karen Watkins, Consultant Ob</td>
</tr>
<tr>
<td>April 12</td>
<td>1.2</td>
<td>Updated in to Trust format</td>
<td>Karen Watkins, Consultant Ob</td>
</tr>
<tr>
<td>September 2012</td>
<td>1.3</td>
<td>Changes to compliance monitoring only</td>
<td>Karen Watkins, Consultant Ob</td>
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<tr>
<td>6th March 2014</td>
<td>1.4</td>
<td>Update of IV antibiotics to IV Ceftriaxone and Metronidazole for 3rd/4th degree tears</td>
<td>Karen Watkins, Consultant Ob</td>
</tr>
<tr>
<td>1st December 2016</td>
<td>1.5</td>
<td>2.5 and 2.6 Updated</td>
<td>Farah Lone, Consultant Obs &amp; Gynae</td>
</tr>
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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
**Appendix 2. Initial Equality Impact Assessment Form**

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): PERINEAL OR GENITAL TRACT TRAUMA FOLLOWING CHILDBIRTH - CLINICAL GUIDELINE FOR IDENTIFICATION AND MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td>Name of individual completing assessment: Elizabeth Anderson</td>
</tr>
<tr>
<td>Telephone: 01872-252879</td>
</tr>
</tbody>
</table>

### 1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?

To give guidance to midwives and obstetricians about the recognition and management of perineal and genital tract trauma following childbirth.

### 2. Policy Objectives*  
To ensure appropriate recognition and management of perineal and genital tract trauma following childbirth.

### 3. Policy – intended Outcomes*  
Ensure appropriate repair of trauma following childbirth.

### 4. *How will you measure the outcome?  
Compliance Monitoring Tool

### 5. Who is intended to benefit from the policy?  
All women following childbirth

### 6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

### 6b) If yes, have these *groups been consulted?  
N/A

### 6c) Please list any groups who have been consulted about this procedure.  
N/A

### 7. The Impact  
Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td>All women following childbirth</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th>All women following childbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No X

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director Obstetric Consultant | Date of completion and submission
Karen Watkins | 6th March 2014

Names and signatures of members carrying out the Screening Assessment
1. Miss Lone
2. Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Sarah-Jane pedler
Date: 15th December 2016
## Appendix 3
### Perineal Suturing Proforma

Date:……………………
Reason for delay (if any):………………………………………..
Location of repair: Room / Theatre

<table>
<thead>
<tr>
<th>Verbal consent given for repair</th>
<th>Yes/No</th>
<th>Written consent obtained</th>
<th>Yes/No</th>
<th>Analgesia used:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labial tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st degree repair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd degree repair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd degree repair</td>
<td>3a</td>
<td>3b</td>
<td>3c</td>
<td></td>
</tr>
<tr>
<td>4th degree repair</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Episiotomy</td>
<td></td>
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<tr>
<td>Cervical tear</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Diagram of tear

### Details of repair (please encircle)

**PR performed:** before repair Yes/No
**Vaginal mucosa:** Continuous/interrupted: Suture material used…………………..

**Muscle:** Continuous/interrupted: Suture material used…………………..

**Skin:** Interrupted / Subcuticular: Suture material used…………………..

**External anal sphincters:** End to end/overlap: Suture material used…………………..

**Internal anal sphincter:** End to end: Suture material used…………………..

**Rectal mucosa:** Continuous /interrupted: Suture material used…………………..

**PR performed:** after repair Yes/No

**Indwelling catheter:** Yes/No

**Blood Loss…………………………………..**

**Comfortable throughout procedure** Yes / No

**Haemostasis achieved** Yes / No

**Vaginal Pack in situ** Yes / No Remove in ……..hours

**Vaginal examination performed** Yes / No

**PR Diclofenac given** Yes / No

**Swab and vaginal roll count correct** Yes / No

**Instrument count correct** Yes / No

**Needles count correct** Yes / No

- **Antibiotics prescribed** Yes / No
- **Laxatives prescribed** Yes / No
- **Analgesia prescribed** Yes / No
- **Risk management datix for 3c and 4th degree tears:** Yes/ No
- **Catheter to be removed:** ………….hours

### Follow up:

- Full explanation given to woman about type of tear and suturing Yes / No
- Discussion with the woman regarding support following the repair Yes/ No
- **Obstetric consultant follow up required at 6-8 weeks** Yes/ No
- Referral to physiotherapy made for 6 weeks Yes/ No
- Patient information leaflet given for 3rd & 4th degree tear prior to discharge Yes/ No

**Print name ………………. Signature…………………………………..**

MW / SHO / SSHO / SPR / Staff grade / Consultant / Other (please specify) …………..