

Perineal Tears – Third and Fourth Degree

Document Type	Guideline
Function(s)	Clinical Service Delivery
Health Service Group (HSG)	Women's Health
Departments affected	Maternity
Staff affected	All clinicians (inc. physiotherapists) in Maternity
Key words	Tear, perineal, OASIS
Author – role only	O&G Consultant, Women's Health and Professional Leader, Physiotherapy
Owner (see ownership structure)	Clinical Director of Obstetrics, Women's Health
Edited by	Clinical Policy Advisor
Date first published	June 2010
Date this version published	December 2011
Date of next scheduled review	December 2014
Unique Identifier	NMP200/GUI/003

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1. Purpose of guideline

This guideline establishes the expected management of 3rd and 4th degree perineal tears within Auckland District Health Board (ADHB).

Tears involving the anal sphincter can have long term sequelae. It is important that all 3rd and 4th degree tears are identified, repaired and followed up with both obstetric and physiotherapy input.

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2. Classification

First degree

Laceration of the vaginal epithelium or perineal skin only.

Second degree

More than 50% involvement of the vaginal epithelium, perineal skin, perineal muscles and fascia, but **no** involvement of the anal sphincter.

Third degree

This involves disruption of the vaginal epithelium, perineal skin, perineal body and anal sphincter muscles. This should be further subdivided into:

- 3a:** partial tear of the external sphincter involving less than 50% thickness;
- 3b:** more than 50% of thickness involved or complete tear of the external sphincter;
- 3c:** internal sphincter also torn.

Fourth degree

A third degree tear plus disruption of the anal ± rectal epithelium.

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3. Surgical recognition and repair of tear

Up to 30% of 3rd/4th degree tears go unrecognised at delivery. All skin tears that extend to the anal margin are 3rd degree tears until proven otherwise by the charge midwife. If in doubt examine in lithotomy and do a rectal exam (PR) to ascertain the extent.

- a) Repairs should be performed by/under supervision of a consultant or a senior registrar.
- b) All repairs must be conducted in the operating room where there is access to good lighting, appropriate equipment and aseptic conditions.
- c) All repairs must be performed under general or regional anaesthesia. This is an important prerequisite as the inherent tone in the sphincter muscle can cause the torn muscle ends to retract within its sheath. Muscle relaxation is necessary to retrieve the ends and overlap or appose without tension.
- d) The full extent of the injury should be evaluated by a careful vaginal and rectal examination in lithotomy and the tear should be classified as above.
- e) Possible complications of repair during consenting for repair must include flatus and/or faecal incontinence and RVF especially in 4th degree repair.
- f) The torn anal skin must be repaired with interrupted Vicryl 3-0 sutures and the knots tied in the anal lumen or a continuous sub mucosal stitch.
- g) An attempt must be made to identify internal anal sphincter tear and repaired separately by end to end approximation with interrupted 3/0 PDS sutures. These sutures are monofilamentous and therefore less likely to precipitate infection compared to a braided suture. Although non-absorbable monofilament sutures such as Nylon prolene can be equally effective, a long lasting absorbable suture is preferable because non-absorbable sutures can cause stitch abscesses and the sharp ends of the suture can cause discomfort necessitating removal.
- h) The torn ends of the external anal sphincter must be identified and grasped with Allis tissue forceps. The muscle is then mobilised and pulled across to overlap in a "double-breast" fashion or apposed with 3/0 PDS (Ethicon) sutures. Partial disruption and sphincter is repaired by 'end to end' approximation using 3-OPDS.
- i) Great care must be exercised in reconstructing the perineal body and muscles to provide support to the sphincter repair. The anal sphincter is more likely to be traumatised during a subsequent vaginal delivery in the presence of a short deficient perineum, subsequent continence is dependent on length of anal canal and good perineal body would result in good length of anal canal.

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4. Immediate post-op management

- a. Severe perineal discomfort is a known cause of urinary retention and following regional anaesthesia it can take up to 12 hours before bladder sensation returns. Therefore a Foley's catheter should be left in for at least 24 hours;
- b. Intravenous antibiotics (Cefuroxime 1.5g and Metronidazole 500mg) should be given stat intra-operatively. Change to oral antibiotics on the ward;
- c. Oral antibiotics should be prescribed to complete 7 days of treatment in total: Augmentin 625mg tds alone; if allergic co-trimoxazole 960mg bd and metronidazole 400mg bd;
- d. All women should be prescribed stool softeners (Lactulose 15mls bd) and a bulking agent (Metamucil 2 x 5ml spoonfuls bd) for 2 weeks as straining to pass a bolus of hard stool may disrupt the repair;
- e. Postoperatively the woman must be given a detailed explanation of the extent of trauma. She should be made aware that input from a specialist would be necessary in her next pregnancy to discuss mode of delivery;
- f. An appointment made for 3rd degree tear clinic in 6 weeks.

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5. Documentation requirements post-op before discharge to midwifery care

- Full operative records both written and dictated
- See [Associated ADHB documents](#) for referral letter to Perineal Tear Clinic
- [ACC Treatment Injury form](#) (ACC 2152) completed manually by the surgeon, at the time of the operation (only if the tear is related to treatment, e.g. episiotomy or instrumental delivery)
- ACC 45 on line form to be initiated by Labour and Birthing Ward Clerk, and clinical details completed by a member of the team. (only if the tear is related to treatment, e.g. episiotomy or instrumental delivery, otherwise please advise the Ward Clerk not to start the online claim)
- See [Associated ADHB documents](#) for letter to patient

Discharge to midwifery care cannot occur until the above are completed.

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6. Physiotherapy referrals

The physiotherapist should check white boards daily for 3rd and 4th degree perineal tears as well as the referral books on Tamaki ward

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7. Physiotherapy days one two and three

a. Advice

- Rest, lying prone or side lying, with the bed flat
- Apply ice, 2 to 4 hourly for 10 minutes, until swelling subsides (MacAuley, 2001)
- Ensure good pain relief
- Whilst sitting to feed the baby, use folded towels under the thighs to relieve pressure on the perineum
- Sitting posture advice
- Educate optimum toileting position with good void and defecation technique
- Wound hygiene by cleaning stitches after toileting with warm water from a hand held shower. Pat dry with toilet paper
- Perineum support during defecation, coughing and sneezing
- Stool softening, discuss way to achieve this, recommending type 3 and 4 on the Bristol Stool Chart (Lewis & Heaton, 1997)
- Advise on safe lifting techniques and posture
- Check for any incontinence or bladder retention problems

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b. Pelvic floor exercises

- Encourage gentle exercises from day 1
- Gently squeeze and lift around the urethra and/or anal sphincter, hold for 3 seconds, rest for 3 seconds and repeat 5 times as able
- If there is no sensation, cease the exercises and try again in 24 hours
- Exercise within limits of pain for days 1 to 7
- Increase levels of endurance and strength over the first 6 weeks

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c. Transversus abdominal exercises

- Check transversus abdominus activation and technique
- Encourage gently drawing in the lower abdominals for 5 seconds whilst exhaling
- Gradually build up the endurance to 30 seconds

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d. The knack

- Encourage simultaneous pelvic floor and transversus abdominus contractions functionally on coughing, bending, lifting and bed transfers

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8. Physiotherapy six week follow up at perineal tear clinic

Ensure the patient has been referred to the Perineal Tear Clinic for a six week follow up. Patients with private obstetricians are not eligible for the Perineal Tear Clinic, therefore advise these patients on private alternatives. Check for:

- Bladder dysfunction, e.g. retention, incontinence and/or urgency
- Bowel dysfunction (Flatus, faecal soiling, incontinence or urgency). See [Associated ADHB documents](#) for Perineal Tear Bowel Questionnaire
- Perineal pain
- Sexual dysfunction

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9. Physiotherapy physical examination

- i Obtain verbal consent;
- ii Assess external muscle function including abdominal diastasis and TA;
- iii Observe the perineum for:
 - Cleanliness and hygiene
 - Bruising and swelling
 - Signs of infection
 - Integrity of sutures and the wound
 - Haemorrhoids
 - Haematoma
 - Prolapse
 - Assess vaginally for pelvic floor strength including endurance, repetition and speed
- iv Provide a rehabilitation program and offer follow up as required.

Refer the patient back to the obstetrician if any concerns are raised. Also ensure the patient is aware of how to seek further assessment if required at a later date.

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10. Physiotherapy education

- Lifestyle modification e.g. weight loss, exercise, posture and lifting
- Dietary interventions e.g. fibre and fluid intake, eating patterns and caffeine restriction
- Good toileting habits and avoiding constipation

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11. Supporting evidence

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- Yimaz E. [Manometric evaluation of anal sphincter function after vaginal and caesarean delivery](#). Int J Gyn and Obs 2008:103(2).
- The Royal Women's Hospital. [Third and fourth degree tears: management](#).

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12. Associated ADHB documents

[Informed Consent](#)

[Intrapartum Care - Normal Labour & Birth](#)

[Perineal Tear Clinic Referral \(letter\)](#)

[Perineal Tear Bowel Questionnaire](#)

[Third and fourth degree tears following childbirth \(letter to patient\)](#)

Third and Fourth Degree Tears Following Vaginal Delivery (physiotherapy patient information – hard copies only available, currently)

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13. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

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14. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or the [Clinical Policy Advisor](#) without delay.

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