

## PERINEAL TEAR CLINIC: GLCC

All patients delivering at ACH or Birthcare, who have suffered a third degree tear, should be referred to Perineal Tear Clinic (unless they have a private Obstetrician). Any other patient who later has problems either from an episiotomy or a second degree tear may also be referred to the clinic, including from private Obstetricians. It is important to fill in the correct referral form and if she had an instrumental delivery, fill in an ACC form.

There is no need for patients to fill out any questionnaire prior to being seen at the clinic.

### Classification of Perineal Tears (RCOG, 2001)

- First Degree:* Laceration of the vaginal epithelium or perineal skin only
- Second Degree:* Involvement of the vaginal epithelium, perineal skin, perineal muscles and fascia but not the anal sphincter.
- Third Degree:* Disruption of the vaginal epithelium, perineal skin, perineal body and anal sphincter muscle. This should be further subdivided into:
- 3a partial tear of the external sphincter involving less than 50% thickness
  - 3b >50% - complete tear of the external sphincter
  - 3c internal sphincter also torn
- Fourth Degree:* A third degree tear with disruption of the anal +/- rectal epithelium.

### Perineal Tear Follow-up clinic:

Ideally the patient's first visit is at 6 weeks post partum. At this visit she can see either the physiotherapist or a doctor. If a patient has never had physiotherapy she needs to see the physio at her first clinic visit. Follow up can be with either the physio or the doctor. She needs to see a doctor at least once prior to discharge. Even if a patient is not booked for the doctor/physio but there is an indication for her to be seen urgently she should be seen at that clinic and not asked to return later.

- 1) Ensure all patients have completed an ICIQ – bowel, and AQUA - bladder questionnaires.
- 2) Review Obstetric notes – ensure patient understands the circumstances surrounding their delivery and provide explanation if any concerns. Be aware the patient's delivery may have been very traumatic. Watch for PND/PTSD. Refer to Women's Health Psychology if indicated.
- 3) Clinical questions relating to; bowel urgency, frequency, stool consistency, incontinence; bladder function and incontinence; pads and sexual function including dyspareunia etc.
- 4) Genital examination:  
Look specifically for scarring, granulation tissue, tenderness. Assess pelvic floor tone. Measure perineum length (posterior fourchette – anterior anal margin) and perineal body (perineal body bulk by rectal – vaginal palpation)

and PR (if clinically indicated) – examine for defects and assess anal sphincter tone by digital examination.

1. Granulation tissue can usually be treated in the procedure room on the day of clinic. There is local anaesthetic, small instrument sets and silver nitrate available.
  2. More complex revision of scars needs to be booked for a day stay procedure.
  3. For superficial dyspareunia and scar tissue needing stretching prescribe topical lignocaine gel (PS remind the patient to wipe the gel off prior to intercourse or ask her husband to use a condom – he has no reason to be anaesthetised)
- 5) Translabial/transperineal USS is useful for assessing puborectalis avulsion injury, sphincter integrity and prolapse. If an USS is indicated arrange for it to happen on a Friday morning, prior to the patient's next clinic appointment.
- 6) Discuss management of subsequent pregnancies.

*2 major issues:*

- 1. *Risk of OASIS recurrence – (overall risk – 5%)*
  - 2.1% if no episiotomy
  - 11% if midline episiotomy
  - 21% if midline episiotomy and instrumental delivery
- 2. *Risk of developing anal incontinence after subsequent pregnancy*

**Decision regarding mode of delivery should depend on symptomatology and clinical evaluation.**

- a) Asymptomatic patient with good perineal body, sphincter tone and >3cm perineal length may be offered a vaginal delivery being aware of a 95% chance of not sustaining a recurrent OASIS or de novo anal incontinence. Avoid midline episiotomy/instrumental delivery esp. forceps and if concerns intrapartum of traumatic delivery (Large baby, persistent OP, Slow progress) offer LSCS early.
- b) All symptomatic patients should be offered LSCS next pregnancy to prevent worsening of symptoms. If mild symptoms, offer patient dietary advice – if flatus incontinence, avoid gas producing foods eg. Legumes and trial bulking agents eg. Fybogel/Metamucil bd. If BM loose eg. Loperamide. If severe symptoms of faecal incontinence referred to colorectal team of consideration of secondary sphincter repair. All patients with secondary sphincter repair should be delivered by Elective LSCS.
- c) Patients with transient symptoms that have resolved. There is limited data available therefore individualisation required.

Arrange follow up visit as clinically indicated. There are no "routine" follow up visits and no "routine" investigations.