

Perineal Tears - Third and Fourth Degree (OASIS)

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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 (Auckland DHB).

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.

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.

Obstetric Anal Sphincter Tears (OASIS)

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.

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.

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 (cefazolin 2g and Metronidazole 500mg) should be given stat intra-operatively. Change to oral antibiotics on the ward;
- c) Oral antibiotics should be prescribed to complete 5 days of treatment in total: co-amoxiclav 625mg tds alone; if allergic co-trimoxazole 960mg bd and metronidazole 400mg bd;
- d) All women should be prescribed stool softeners (lactulose 15 mL bd) and a bulking agent (Konsyl-D® 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) Referral to gynaecology clinic is made by faxing the Perineal Tear Record to the Central Referrals Office. Referrals will be triaged as follows.
- g) 3A tears - to general gynaecology clinic of the team who performed the repair
- h) Greater than 3A - to Urogynaecology clinic
- i) Out of area patients - still need to be seen in Auckland DHB gynaecology as follow up, if birth was at Auckland DHB
- j) However out of area patients will be seen by Physiotherapy at their DHB of domicile

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

- Full operative records both written and dictated
- Complete the Perineal Repair Record (CR4097 - see [clinical form](#)) including the discharge checklist on the reverse side and fax it to the CRO (Fax 6380402)
- ACC Treatment Injury form (ACC 2152 - see [other resources](#)) completed manually by the surgeon at the time of the operation (only if the tear is related to treatment, eg episiotomy or instrumental delivery)
- ACC 45 on line form to be initiated by the Labour and Birthing Ward Clerk and, clinical details completed by a member of the team (only if the tear is related to treatment eg episiotomy or instrumental delivery, otherwise please advise the Ward Clerk not to start the online claim)
- See [other resources](#) for letter to patient

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

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.

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

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

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

d) The knack

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

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 eg retention, incontinence and/or urgency
- Bowel dysfunction (Flatus, faecal soiling, incontinence or urgency) see [other resources](#) for Perineal Tear Bowel Questionnaire
- Perineal pain
- Sexual dysfunction

9. Physiotherapy physical examination

- Obtain verbal consent;
- Assess external muscle function including abdominal diastasis and TA;
- 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
- 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.

10. Physiotherapy education

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

11. 6 week gynaecology outpatients review

Review symptoms - can use standardised questionnaire, such as the Rockwood Faecal Incontinence Quality of Life Assessment or the St Marks score (below), or the shortened ICIQ-B questionnaire (see [other resources](#)).

	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Weekly</i>	<i>Daily</i>
Incontinence for solid stool	0	1	2	3	4
Incontinence for liquid stool	0	1	2	3	4
Incontinence for gas	0	1	2	3	4
Alteration in lifestyle	0	1	2	3	4
				<i>No</i>	<i>Yes</i>
Need to wear a pad or plug				0	2
Taking constipating medicines				0	2
Lack of ability to defer defecation for 15 minutes				0	4

Never, no episodes in the past four weeks; rarely, 1 episode in the past four weeks; sometimes, >1 episode in the past four weeks but <1 a week; weekly, 1 or more episodes a week but <1 a day; daily, 1 or more episodes a day.

Add one score from each row: minimum score = 0 = perfect continence; maximum score = 24 = totally incontinent.

- Examine - pelvic floor muscle tone, degree of scar tissue, anal tone
- Treat any residual problems - scar tissue pain, loose stools etc
- Determine whether on-going Physio is needed
- Review notes and be very familiar with context in which tear occurred and the repair technique used
- Debrief patient and answer key questions as best as able

Offer follow up appointment for 6 months

To address any issues that may not reveal themselves until they are back to usual activities - sex, exercise etc. Patients may wish to cancel this appointment closer to the time if all is well, but all should have a 6 month clinic appointment booked after 6 week review.

Refer to Colorectal services if:

- High St Marks scores at 6 weeks (>9)
- Concurrent bowel history such as ulcerative colitis
- Inability to control moderate anal incontinence symptoms at 6 months despite usual treatments

12. Supporting evidence

- Royal College of Obstetricians & Gynaecologists (RCOG). [Third and Fourth-degree Perineal Tears, Management](#). *Green Top Guidelines No. 29*, March 2007.
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- The Royal Women's Hospital. (2017). [Third and fourth degree tears: management](#).

13. Associated Auckland DHB documents

- [Antimicrobial Stewardship - Surgical Antimicrobial Prophylaxis](#)
- [Informed Consent](#)
- [Intrapartum Care - Normal Labour & Birth](#)

Clinical form

- [CR:4097 Perineal Injury Repair Record](#)

Other resources

- [ACC:2152 ACC Treatment Injury Claim](#)
- [Advice for Third and Fourth Degree Tears Following Vaginal Delivery](#)
- [Birthcare Medication Sheet](#)
- [OASIS letter](#)
- [Perineal Tear Bowel Questionnaire \(shortened ICIQ-B\)](#)
- [Perineal Tear Clinic Referral \(letter\)](#)
- [Rockwood Quality of Life Assessment](#)
- [Third and fourth degree tears following childbirth \(letter to patient\)](#)

14. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB 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.

15. 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.