Perineal Care

Clinical Guideline Presentation v4.0

45 minutes

Towards CPD Hours

Clinical Excellence Queensland

Queensland Government

References:

Queensland Clinical Guideline: Perineal care is the primary reference for this package.

Recommended citation:

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Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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Abbreviations

Word	Abbreviation
Anal sphincter	AS
External anal sphincter	EAS
Internal anal sphincter	IAS
Female genital mutilation	FGM
Obstetric anal sphincter injury/injuries	OASIS
Pelvic floor muscle training	PFMT

Objectives

- Become familiar with the standard perineal tear classifications
- Identify risk factors for perineal injury and obstetric anal sphincter injury (OASIS)
- Identify antenatal and intrapartum risk reduction strategies
- Outline principles for postnatal perineal assessment and repair
- Outline postnatal care and perineal considerations
- Outline care principles and management for women who have experienced female genital mutilation (FGM)

Perineal tear classification

Tear	Definition	
First degree	Injury to the skin or vaginal epithelium only	
Second degree	Injury to the perineum involving perineal muscles but not involving the anal sphincter	
Third degree	Injury to perineum involving the anal sphincter complex • 3a: Less than 50% of external anal sphincter (EAS) thickness torn • 3b: More than 50% of EAS thickness torn • 3c: Both EAS and internal anal sphincter (IAS) torn	Third and fourth degree tears are collectively known as **OASIS**
Fourth degree	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium	
Rectal buttonhole	• Injury to rectal mucosa with an intact anal sphincter • Not a fourth degree tear	

Antenatal risk reduction

Emma is having her second baby, is 30 weeks pregnant and is attending a routine antenatal appointment.

How can you help Emma reduce the risk of perineal injury?

- Review history for perineal trauma
- Consult and refer if required (e.g. if FGM, OASIS, fetal macrosomia)
- Review risk factors
- Offer information about antenatal strategies that reduce risk
  - Antenatal perineal massage
  - Pelvic floor muscle training (PFMT)

Risk factors for OASIS

- Previous OASIS
- First vaginal birth
- Increased maternal age
- OP, OT position
- Post-term birth
- Birth weight >4 kg (>3.5 kg if Southeast Asian ethnicity)
- Instrumental birth
- Shoulder dystocia
- Midline episiotomy

Offer all women information about of the risk of perineal injury, including OASIS

Intrapartum risk reduction

Emma discusses her preferences about intrapartum perineal management. You record them in the health record.

Emma would like to:

- Use warm perineal compresses
- Position herself however she feels most comfortable
- Probably avoid perineal massage, but would like to be asked again during second stage as she might re-consider at the time
- Avoid episiotomy, unless the baby is distressed

Effective verbal communication with the woman can guide active pushing, slow expulsive efforts and promote controlled pushing at crowning

Episiotomy

Emma presented in active spontaneous labour and progressed quickly to second stage. Birth was expedited with an episiotomy following a prolonged fetal bradycardia and with Emma's consent.

What are considerations for restrictive use of episiotomy?

- Clinical decision making is based on:
  - Discussions with Emma and her preferences
  - Individualised assessment (e.g. state of perineum, fetal condition)
  - Type of birth (spontaneous or instrumental)
- Mediolateral episiotomy is performed at crowning:
  - Following administration of local anaesthetic
  - Cut at an angle of 60 degrees from the fourchette

Perineal assessment

Emma births a healthy baby boy. Following birth, a perineal assessment is conducted using a systematic process.

Element	Systematic process for perineal assessment
Timing and preparation	• Conduct as soon as possible after birth • Discuss process with the woman and gain informed consent • Offer analgesia • Ask the woman to position herself to enhance visualisation
Visual assessment	Visualise: • Peri-urethral area, labia, proximal vaginal walls • End point of tear (e.g. does tear extend to anal margin or anal sphincter (AS) complex) • Presence or absence of anterior anal puckering
Vaginal examination	• Check cervix, vaginal vault, side walls, floor & posterior perineum • Identify apex of injury
Rectal examination	Check for: • Separated ends of a torn external anal sphincter (EAS) - is there retraction backwards? • Inconsistencies in AS muscle bulk • Integrity of anterior rectal wall
Diagnosis	• Grade the degree of injury • Double check assessment and grading with senior clinician as required • Discuss findings with the woman

Perineal assessment

While assessing Emma's perineum you are concerned the episiotomy may have extended to a third-degree tear

What might alert you to a possible OASIS?

- Emma's risk factors for OASIS (first vaginal birth)
- Signs of possible OASIS including:
  - Episiotomy visually extending to anal margin or anal sphincter complex
  - Absence of puckering around anus
  - Vaginal examination revealing a torn sphincter
  - Rectal examination demonstrating a gap/inconsistency in sphincter

If in any doubt, refer to more experienced clinician!

Perineal repair

Following completion of the assessment, with the support of an experienced clinician, no extension of the injury is identified. Emma is informed that her episiotomy is classified as a second-degree injury.

What principles guide perineal repair?

- Following discussion about risks and benefits of repair
- Informed consent for the repair is given
- Repairs are undertaken as soon as practicable following birth
- Aim for minimal interference to mother-baby interactions
- Performed only by clinicians trained and assessed as competent
- Seek advice and refer if unsure of classification

Puerperal genital haematoma

Soon after arriving in the postnatal ward, Emma complains of difficulty passing urine, vaginal pain and pressure ‘down below’.

What symptoms and/or findings are associated with genital haematoma?

- Hallmark symptom is excessive and/or persistent pain
- Pelvic pressure
- Urinary retention
- Unexplained pyrexia
- Signs of hypovolaemia that are disproportionate to vaginal bleeding
- Identification of a mass (e.g. purple swelling may appear on the labia; a compressible mass protruding through the vagina)

Postpartum care

Emma's vital signs are stable and after additional analgesia, Emma passes urine and is feeling more comfortable.

What information do you give Emma about perineal care?

- Use positions that reduce perineal oedema, especially in first 48 hours (e.g. side lying)
- Avoid activities that increase intra-abdominal pressure (e.g. sit-ups)
- Commence pelvic floor muscle exercises
- Hygiene tips, and the signs of wound breakdown and infection
- Importance of avoiding constipation
- Resumption of sexual activity
- When to seek further advice (e.g. signs of infection, wound breakdown, dyspareunia, incontinence)

OASIS management considerations

What care will you consider for women who experience OASIS?

- Antibiotic prophylaxis prior to repair
- Repairing the injury in the operating theatre
- Indwelling urinary catheter may be used
- Referral (where available) to:
  - Women's Health Physiotherapy
  - Continence clinic
- Specialist perineal obstetric clinic
- Refer for postpartum obstetric review at 6-12 weeks
  - If ongoing symptoms persist (e.g. dyspareunia, incontinence) further referral and/or investigations may be required (e.g. endoanal ultrasound)
- Counselling for future births
- No high-level evidence to recommend optimal mode of birth

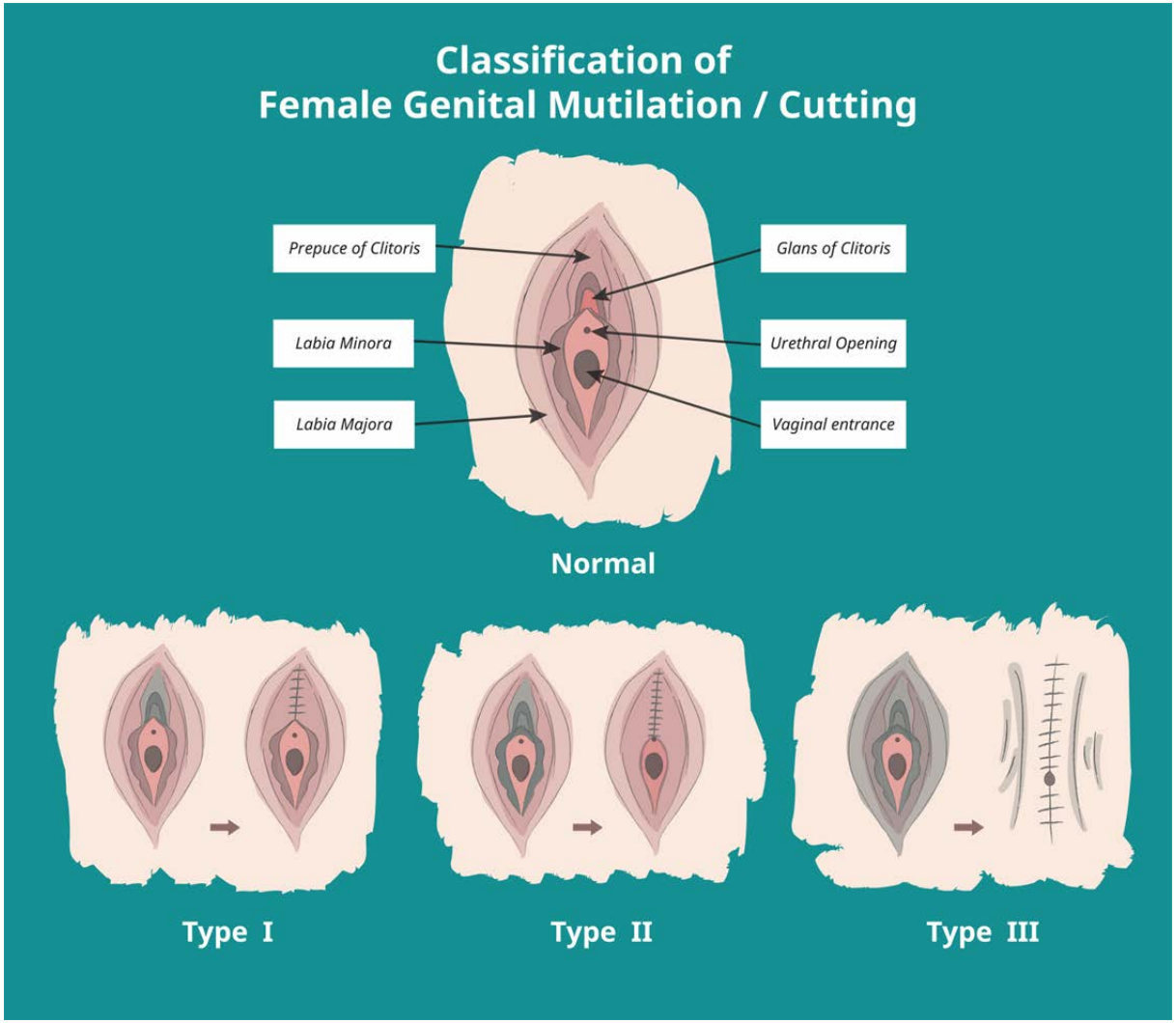
Female genital mutilation (FGM)

FGM is an umbrella term for procedures that involve the partial or total removal of external genitalia, or other injury to the female genital organs for non-medical reasons.

FGM classification

Type	Classification
I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
IV	All other harmful procedures to the female genitalia for non-medical purposes (e.g. pricking, piercing, incising, scraping and cauterising)

FGM classification



FGM

Jamila presents for her first booking in appointment at 18 weeks pregnant with her first baby. In discussion, you identify that Jamila has been subject to FGM

What principles will guide your discussion about FGM with Jamila?

- Consider the terminology you use:
  - The term “mutilation” may not be acceptable to women who have experienced FGM,
  - “Cutting” is a commonly accepted term
  - Avoid using the term “female circumcision” (can infer a medical indication may exist))
- Consult and/or refer to a clinician trained in the management of women with FGM wherever possible
- FGM and reinfibulation are illegal in Australia

Ask all women for a history of FGM, preferably in the absence of a partner

Deinfibulation

Jamila asks if the baby will be able to be born vaginally

What will you discuss with Jamila?

- No difference in outcomes between vaginal or caesarean birth
- Deinfibulation recommended if narrowing of introitus prevents normal menstrual flow, comfortable sexual intercourse and safe vaginal birth
- Deinfibulation can occur during pregnancy (generally in the 2nd trimester), in labour or perioperatively after caesarean
- May require additional intrapartum care (IV access, full blood count and group and hold in established labour)
- Re-infibulation is illegal in Australia