

5 INTRAPARTUM CARE

5.15 PERINEAL REPAIR

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5.15.1 Suturing an Episiotomy / Genital Laceration
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

5.15.1 SUTURING AN EPISIOTOMY/GENITAL LACERATION

KEY POINTS

- At King Edward Memorial Hospital:
 - all staff must be able to demonstrate clinical competence in suturing an episiotomy and/or genital laceration before undertaking the procedure without supervision.¹
 - demonstration of competence at intervals of not more than 3 years is required if the clinician undertakes less than 5 perineal repairs per year.
 - competency is assessed by an accredited staff member.
 - a dedicated suturing of an episiotomy or genital laceration program is conducted by Labour and Birth Suite staff for those who have no previous experience with the procedure, or who have not been deemed competent.¹
 - a register is kept in the Labour and Birth Suite of those midwives who are in the training program, those who have been certified as competent, the accredited trainers and the date by which review is required.
 - assistance with suturing of an episiotomy or a genital laceration is available at any time should staff be uncertain about the repair, even though they have been certified competent.
- Repair of the perineum should be undertaken as soon as possible to decrease the risk for infection and blood loss.²
- Undertaking the suturing of an episiotomy or genital laceration is an aseptic procedure.
- Radio-opaque abdominal swabs and tampons must be used at all times.
- The operator and the assistant are equally responsible for ensuring that all equipment used, including 'sharps', are accounted for at the end of the procedure and documented on the MR275.
- The operator is responsible for safe disposal of all 'sharps' used prior to leaving the room.
- Continuous rather than interrupted sutures for repair of the vagina and perineal muscles with subcuticular suturing to the skin is associated with reducing pain short term perineal pain.³
- Use of an absorbable synthetic suture material such as polyglycolic acid and polyglactin 910 (Dexon, Vicryl or Polysorb) is associated with less perineal pain, analgesia use, dehiscence and need for resuturing, but is linked to increased suture removal when compared to catgut.^{4, 5}
- Current evidence indicates a more rapidly absorbed synthetic suture material (*Vicryl Rapide™*) when compared to standard Vicryl material is associated with less perineal pain with ambulation or need for suture removal up to 6 months after repair.⁶
- Vicryl Rapide™ is not the suture of choice for women with an increased BMI.
- Women with a first-degree tear should have the wound sutured to assist healing unless the skin edges are well opposed.²

12. Unidentified perineal trauma can lead to post-partum haemorrhage (PPH), vulvovaginal haematoma, shock, faecal and flatus incontinence, wound infection, septicaemia or rectovaginal fistula.⁷
13. Use of non-steroidal anti-inflammatory rectal suppositories is associated with reduced intensity of perineal pain in the first 24 hours after birth, and less additional analgesia is required within the first 48 hours following birth.⁸
14. Women who have undergone deinfibulation during labour are not to be reinfibulated.

EQUIPMENT

Bowl set
 Suture set
 Sterile lithotomy sheet
 Sterile gown and gloves, plastic apron, protective eyewear
 Suture material as requested by the operator
 Local anaesthetic: 1% Lignocaine
 Syringe 20mL
 Needles: 19 gauge (drawing up needle), 22 gauge infiltration needle
 Sterile swabs
 Rampley's sponge forceps
 Abdominal sponges (x-ray detectable only)
 Antiseptic solution
 Comfort care pad
 Stool
 Adequate light source
 Nitrous Oxide and Oxygen gas apparatus
 Lubricant

Extra equipment that may be required include:

Radio-opaque tampon
 Jackson retractors
 Extra artery forceps

	PROCEDURE	ADDITIONAL INFORMATION
1	Preparation	
1.1	Explain the procedure. Obtain maternal consent.	The benefit of repairing an episiotomy and/or laceration as soon as practicable after the birth provides early haemostasis; there is less oedema and swelling present while undertaking suturing, and continued anaesthesia may still be present in the perineal tissues prior to infiltration. Additionally early repairs minimise the risk for infection and blood loss. ²
1.2	Place the woman in a dorsal or lithotomy position and ensure good lighting.	

- 1.3 Ensure the woman is warm and as comfortable as possible.
- 1.4 Don protective apron and glasses and once scrubbed, don sterile gown and gloves
- 1.5 Perform an initial count of all swabs and equipment to be used with an assistant and document on the MR 275.
- Any additional swabs, tampons, instruments or needles required during the procedure are recorded on the MR 275

Allows comparison at the end of the procedure to determine if all swabs and equipment is accounted for.

- 1.6 Swab the perineal area with antiseptic solution e.g. Chlorhexidine and Centrimide irrigation solution.
- 1.7 Place a sterile lithotomy drape over the area to be sutured.

Minimises the risk for infection.⁶

2 Analgesia

Ensure the area to be sutured is adequately anaesthetised by:

- Offering the woman N₂O & O₂ prior to, and during preparation and infiltration of the area or
- Offering the woman an epidural top-up if there is one in progress
- Allow adequate time to elapse before continuing.

Ensure the woman has no allergy prior to infiltration of local anaesthetic.

Withdraw the plunger of the syringe back prior to injecting 10-20mL of local anaesthetic slowly to prevent accidental injection into a blood vessel.⁶

3 Procedure

- 3.1 A vaginal tampon may be inserted. Ask the assistant to record its insertion.

It must be secured to the drape with the artery forceps attached to the tape.

Observe the perineum for excessive blood loss during and following the procedure.

The use of the tampon prevents obscuring of the wound by maternal blood loss.⁴

Attaching the tampon tape to the drape allows improved visibility for removal post procedure.⁹

- 3.2 Examine the area systematically to identify and classify the perineal trauma.

When the assessment discloses extended perineal trauma see:

Clinical Guidelines, Section [B 5.16 Management of third and fourth degree perineal trauma](#).

Assessment should be done with good lighting and visualisation to identify the structures involved. Complicated trauma should be repaired by an experienced practitioner, with consideration of this being performed in theatre.² Misalignment may cause long-term morbidity including dyspareunia.⁶

- 3.3 Identify the apex of the vaginal trauma and insert the first suture 1cm above this point.

Ensures haemostasis of any bleeding vessels that may have retracted above the apex.⁶

3.4 Using a continuous suture, repair the vaginal epithelium first, followed by the perineal muscle, and finally the skin.

Note: two layers of muscle sutures may be required.

Ensure:

- sutures are not over-tightened
- clots are removed from the wound
- dead spaces are not left behind
- hymenal remnants are not sutured

Tight sutures cause unnecessary pain⁴ when reactionary oedema and swelling occur⁶, and may also cause tissue ischaemia which delays healing¹⁰.

Blood clots provide an environment conducive to the growth of bacteria increasing the risk for infection.¹¹

Haemostasis cannot be assured in dead spaces. This predisposes the woman to haematoma formation, pain, infection, and wound breakdown.¹¹

Suturing hymenal remnants may cause dyspareunia.¹¹

4 Management at completion of suturing

4.1 Remove the vaginal tampon

4.2 Check:

- haemostasis has been achieved
- wound edges are apposed.

4.3 Perform a vaginal and rectal examination.

Confirms that the vagina or introitus has not been sutured too tightly, and that no sutures have penetrated the rectal mucosa.⁶

4.4 Clean and dry the perineal area. Apply a pad.

Minimises the risk of infection

4.5 Gently and simultaneously remove the woman's legs from the lithotomy position.

Position the woman in a comfortable position.

4.6 Perform a count of all instruments, swabs, and tampons with a second person and record the count on the MR275

5 Perineal comfort measures

5.1 See [Clinical Guidelines, Section B 6.2.2.2 Perineal Care](#).

There is only limited evidence to support the effectiveness of local cooling treatments to the perineum following childbirth to relieve pain.¹²

5.2 Offer rectal non-steroid anti-inflammatory rectal suppositories for pain relief if there are no contra-indications.

Prophylactic rectal [diclofenac](#) Sodium 100mg rectal suppositories provide effective analgesia after perineal repair in the first 24 hours¹³, and may extend to the second and third day.⁷

6 Documentation

Document the perineal repair on the MR 275 Operative Vaginal Delivery form.

Fulfils statutory requirements and provides an accurate account of the repair.⁶

7 Education

Discuss and provide the woman with the pamphlet 'Caring for your Perineum' which contains information on:

- type of trauma and method of repair²
- suture absorption time
- pain relief²
- diet²
- hygiene²
- resumption of sexual intercourse
- signs of wound infection or breakdown

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