CLINICAL PRACTICE GUIDELINE

Episiotomy / Genital Laceration : suturing

This document should be read in conjunction with the Disclaimer

Aims

- To promote and facilitate standardisation and consistency of practice.
- To guide the suturing of an episiotomy or genital laceration following vaginal birth.

Key Points

1. 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]
    - Midwives shall have1 peer review of their suturing each year .
    - A dedicated suturing of an episiotomy or genital laceration program is conducted by DNAMER/ PGMed and the 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 and the accredited trainers. The date when review is required is discussed at the PDR if / when necessary.
    - 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.
2. Repair of the perineum should be undertaken as soon as possible to decrease the risk for infection and blood loss.[2] The exception to this is following immersion in water during labour and / or a water birth. In this instance suturing should be delayed for up to 1 hour due to water saturation of the tissues.
3. There is limited evidence that not suturing first or second degree perineal trauma is associated with poorer wound healing at 6 weeks. There is no evidence as to long term outcomes.[14]
4. Women should be advised that in the case of first degree trauma, the wound should be sutured in order to improve healing unless the skin edges are well opposed.
5. Women should be advised that in the case of second degree trauma, the muscle should be sutured in order to improve healing.
6. Undertaking the suturing of an episiotomy or genital laceration is an aseptic procedure.
7. Radio-opaque abdominal swabs and tampons must be used at all times.

8. 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.
9. The operator is responsible for safe disposal of all 'sharps' used prior to leaving the room.
10. Continuous rather than interrupted sutures for repair of the vagina and perineal muscles with subcuticular suturing to the skin is associated with reducing short term perineal pain.[3]
11. 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]
12. 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]
13. Vicryl Rapide™ is **not** the suture of choice for women with an increased BMI.
14. Unidentified perineal trauma can lead to post-partum haemorrhage (PPH), vulvovaginal haematoma, shock, faecal and flatus incontinence, wound infection, septicaemia or rectovaginal fistula.[7]
15. 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]
16. Women who have undergone deinfibulation during labour are not to be reinfibulated.

Equipment

- Bowl set
- Suture set
- Sterile lithotomy sheet
- Comfort care pad
- Adequate light source
- Sterile water / 0.9% sodium chloride solution
- Syringe 20mL
- Lubricant
- Stool
- Sterile swabs
- Local anaesthetic: 1% Lignocaine
- Abdominal sponges (x-ray detectable only)
- Nitrous Oxide and Oxygen gas apparatus
- Suture material as requested by operator
- Sterile gown and gloves, plastic apron, protective eyewear
- Needles: 19 gauge (drawing up needle), 22 gauge infiltration needle

Extra equipment that may be required includes:

- 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 the sterile water / 0.9% sodium chloride solution.	Minimises the risk for infection.[6]
1.7	Place a sterile lithotomy drape over the area to be sutured.	
2	**Analgesia**	
	Ensure the area to be sutured is adequately anaesthetised by: • Offering the woman N_20 & O^2 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]

	PROCEDURE	ADDITIONAL INFORMATION
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 Perineal Trauma: Management of Third and Fourth Degree.	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	Tight sutures cause unnecessary pain[4] when reactionary oedema and swelling occur[6], and may also cause tissue ischaemia which delays healing[10].
	• clots are removed from the wound	Blood clots provide an environment conducive to the growth of bacteria increasing the risk for infection.[11]
	• dead spaces are not left behind	Haemostasis cannot be assured in dead spaces. This predisposes the woman to haematoma formation, pain, infection, and wound breakdown.[11]
	• hymenal remnants are not sutured	Suturing hymenal remnants may cause dyspareunia.[11]

	PROCEDURE	ADDITIONAL INFORMATION
4	**Management at completion of suturing**	
4.1	Remove the vaginal tampon	
4.2	Check: • Haemostasis has been achieved. • Wound edges are opposed.	
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 muscosa.[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 Perineal Care Clinical Guideline	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 hours[13], 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]

	PROCEDURE	ADDITIONAL INFORMATION
7	**Education** Discuss and provide the woman with the pamphlet 'Caring for your Perineum' which contains information on: • type of trauma and method of repair[2] • suture absorption time • pain relief[2] • diet[2] • hygiene[2] • resumption of sexual intercourse • signs of wound infection or breakdown	

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Related policies

OD 0324/11 Consent to Treatment for the Western Australian Health System 2011

Related WNHS policies, procedures and guidelines

Perineal Trauma: Management of Third and Fourth Degree

Perineal Care

Keywords:	episiotomy, vaginal tear repair, perineal repair, vaginal suturing		
Document owner:	OGID		
Author / Reviewer:	Evidence Based Clinical Guidelines Co-ordinator		
Date first issued:	April 2003		
Last reviewed:	January 2016	Next review date:	January 2019
Endorsed by:	OGCCU Management Committee	Date:	January 2016
Standards Applicable:	NSQHS Standards: 1 Clinical Care is Guided by Current Best Practice		

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