

PERINEAL TRAUMA AT VAGINAL DELIVERY



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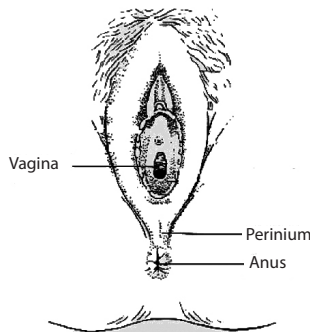
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Perineal Tears

Perineum is the area between the vaginal opening and the anus (back passage). Around 85% of women sustain some degree of trauma following vaginal birth, be it intentional in the form of episiotomy (a cut made in the perineum to enlarge the vaginal opening to help the birth of the baby) or a spontaneous perineal tear. Approximately 60% of them require suturing.

A perineal tear can be of four types (degrees):

- A 1st degree tear is a superficial tear of just the vaginal tissue and/or perineal skin.
- A 2nd degree tear involves the vaginal tissue, perineal skin and perineal muscles.
- A 3rd degree tear involves the vaginal tissue, perineal skin and perineal muscles that extends into the anal sphincter (the muscle that surrounds the anus)
- A 4th degree tear goes through the anal sphincter and the tissue underneath it (the anal mucosa – the innermost lining of anal canal).



Third and Fourth Degree Tears

Around 3 in every 100 (3%) vaginal deliveries can result in 3rd or 4th degree tears. It is not possible to predict or prevent 3rd / 4th degree tears as they cannot be anticipated always. There are some risk factors that make these tears more likely, for e.g. first vaginal delivery, big baby, occipito – posterior position of head (face to pubis), induced labour, shoulder dystocia (difficulty in delivery of the shoulders after head delivery) or instrumental delivery (vacuum or forceps delivery) but most of these factors are unavoidable.

- If not identified or repaired appropriately, women can suffer from gaseous or faecal incontinence (leakage of solid / liquid stools or gas) and faecal urgency.

- The majority of women with faecal incontinence symptoms following a 3rd or 4th degree tear will experience resolution of their symptoms within the first three months following delivery.
- Women with persistent symptoms (more than first 3 to 6 months) of altered faecal continence may need further evaluation.

Suturing (Stitches)

- A 1st degree tear may require suturing or may be left to heal naturally.
- An episiotomy or a 2nd degree tear requires suturing of the muscles and the skin under the effect of local or regional (epidural or spinal) anaesthesia.
- 3rd and 4th degree tears are more complex and require careful suturing under regional or general anaesthesia, usually in the operation theatre. Absorbable sutures are used for all tears.

Aftercare

- Regular painkillers are required in the initial few days. Rectal suppositories and enemas are to be avoided, especially in 4th degree tears.
- Good personal hygiene is important for proper healing. The perineal area must be kept clean and dry using toilet paper or cotton wipes and regular change of sanitary napkins.
- Sitz bath using warm water twice a day can help ease pain and keep the wound clean.
- A course of antibiotics will be prescribed for one week to minimize the risk of infection.
- Stool softeners will also be prescribed for two weeks to avoid constipation and straining.
- Plenty of fluids and high fibre diet are recommended to bulk the stools and achieve regular bowel movement. A dietician may be available to advise.
- Adequate pelvic floor muscle training can improve bowel control by strengthening the muscles. Physiotherapy can be commenced once the pain subsides.

- Discharge from hospital is advised after one or two bowel movements with reasonable control
- Complete wound healing takes up to 4 to 6 weeks after birth.
- Following discharge from hospital, review in emergency room is advised if there is increased pain, swelling, fever or faecal incontinence.
- Sexual relations can be resumed once the wound heals completely, usually after 6 weeks.

Implications

Most tears heal well when recognized and repaired at the time. It is recommended to attend follow up appointments at 6 weeks, 3 months, 6 months and 12 months after delivery to check for wound healing and identify any residual symptoms.

Symptomatic women may require further evaluation in terms of endoanal ultrasound and anal manometry (pressure studies). If significant muscular defect is identified, secondary repair by a colorectal surgeon can be offered.

Vaginal delivery can be allowed in the subsequent pregnancy if the wound has healed well and there are no symptoms of faecal incontinence. The recurrence risk of sustaining a 3rd or 4th degree tear in subsequent pregnancy is around 3 to 4%.

Delivery by Caesarean section is recommended for women with symptoms or residual sphincter muscle defects on scan or those who underwent secondary repair.