HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Multidisciplinary Policy and Procedure		
Title:	Repair of Perineal Tear		
Applies To:	All Obstetrics and Gynecology Staff and Anaesthetist		
Preparation Date:	January 08, 2025	**Index No:**	L&D-MPP-038
Approval Date:	January 22, 2025	**Version :**	2
Effective Date:	February 22, 2025	**Replacement No.:**	L&D-DPP-038(1)
Review Date:	February 22, 2028	**No. of Pages:**	03

1. PURPOSE:

1.1 To ensure most appropriate perineal repair and avoid complications.

2. DEFINITIONS:

2.1 **Perineal tear**- is a laceration of the skin and other soft tissue structures which, in women, separate the vagina from the anus.

3. POLICY:

3.1 Perineal trauma may occur spontaneously during vaginal birth or by a surgical incision (episiotomy)
3.2 Spontaneous tears are defined as:
- 3.2.1 First degree; injury to the skin only.
- 3.2.2 Second degree; injury to the perineum involving perineal muscles but not involving anal sphincter.
- 3.2.3 Third degree; injury to the perineum involving the anal sphincter complex:
  - 3.2.3.1 Less than 50% of External Anal Sphincter (EAS) thickness torn.
  - 3.2.3.2 More than 50% of EAS thickness torn.
  - 3.2.3.3 Internal Anal Sphincter (IAS) torn.
- 3.2.4 Fourth degree; injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium.

3.3 The following basic principles should be observed when performing perineal repairs:
- 3.3.1 Always ensure privacy for the patient.
- 3.3.2 Suture as soon as possible following delivery to reduce bleeding and risk of infection.
- 3.3.3 Check equipment and count swabs prior to commencing the procedure and count again following completion of the repair.
- 3.3.4 Good lighting is essential to visualize and identify the structures involved.
- 3.3.5 Ask for more experienced assistance if in doubt regarding the extent of trauma or structures involved.
- 3.3.6 Difficult trauma should be repaired by an experienced operator in theatre under regional or general anaesthesia. Insert an indwelling catheter for 24 hours to prevent urinary retention.
- 3.3.7 Ensure good anatomical alignment of the wound and give consideration to cosmetic results.
- 3.3.8 Rectal examination after completing the repair will ensure that suture material has not been accidentally inserted through the rectal mucosa.
- 3.3.9 Following completion of the repair, inform the woman regarding the extent of trauma and discuss pain relief, diet, hygiene and the importance of pelvic floor exercises.

4. PROCEDURE:

4.1 Maintain standard infection control precautions at all times, perform hand hygiene with 2% chlorhexidine hand wash before donning:

4.1.1 Protective eye wear.
4.1.2 Plastic apron.
4.1.3 Sterile gown, gloves.

4.2 Sufficient analgesia and anaesthesia should be used during procedure.

4.3 Prepare area; prepare equipment, position patient in the lithotomy position. adjust light source

4.4 Anaesthesia:

4.4.1 Using aseptic technique draws 10 - 20ml of plain Lignocaine Hydrochloride 1%, discard needle and check local anaesthetic. The maximum dose of Lignocaine Hydrochloride 1% plain (10 mg/ml) should not exceed 200mg in total. This maximum dosage is to cover both the infiltration prior to performing an episiotomy and the infiltration required for perineal repair.

4.4.2 Check if the mother has any known allergies to local anaesthesia, infiltrate the wound with Lignocaine HCL 1% plain (10mg/ml) a maximum amount of 3mg/kg may be administered over one hour period, this total includes infiltration used prior to the performance of episiotomy. The maximum dosage is to cover both the infiltration prior to performing an episiotomy and the infiltration required for perineal repair.

4.4.3 Insert needle in the wound edges, first from fourchette, along the posterior vaginal wall to the apex of the wound, before injection of the anaesthesia withdraw the syringe plunger to ensure the needle has not entered blood vessels. The local anaesthesia is injected as the needle is withdrawn, wait 2-3 minutes to ensure anaesthesia is effective.

4.4.4 Check sensation around the wound.

4.5 Repair Vaginal Wall

4.5.1 Insert anchor stitches 0.5 cm above the apex of the wound.

4.5.2 Suture posterior vaginal wall with continuous interlocking stitches from apex of the wound to the introitus, placing bites 1 cm from the wound edges. Each bite being approximately 0.5 cm below the preceding bites taking only the vaginal wall. Bites taken too deep especially near introitus may penetrate rectal mucosa leading to rectovaginal fistula.

4.5.3 Once the vagina is repaired, the sutures should be tied at the level for fourchette. If the operator planes to use interrupted sutures to the muscle layers.

4.5.4 If the continuous sutures to the muscle layer are performed, the final suture layer is made into muscle at the fourchette.

4.6 Repair of Perineal Muscles

4.6.1 The muscle layer is opposed in one or two layers dependent on the depth of wound, interrupted or continuous sutures may be used.

4.6.2 Dead space should be eliminated as much as possible to reduce the risks of infection, wound breakdown.

4.7 Skin Repair

4.7.1 Subcutaneous.

4.7.2 Interrupted. The use of a continuous subcuticular technique for perineal skin closure is associated with less short term pain than techniques employing interrupted sutures.

4.8 Suture Material

4.8.1 Vicryl 2/0, Dexone 2/0 on an eyeless round bodies 40 mm 1/2 circle needle is to be used for the repair of the vaginal mucosa and perineal muscles.

4.8.2 Vicryl 3/0, Dexone 2/0 on an eyeless round bodies 25mm 1/2 circle needle is to be used for repair of the perineal skin. The use of absorbable synthetic material (polyglycolic acid and polyglactin 910) for repair of perineal trauma is associated with less perineal pain, analgesic use, dehiscence and resuturing, but increased suture removal, when compared with catgut.

5. MATERIALS AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician

6.2 Anesthetist
6.3 Nurses
6.4 Midwives

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013.
8.2 https://en.wikipedia.org/wiki/Perineal_tear.

9. APPROVALS:

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