Sultanate of Oman

Approved Document

Ministry of Health

Directorate General of Khoula Hospital

Directorate of Obestetric&Gynecology

Institution Name: Directorate General of Khoula Hospital

Document Title: Protocol for Episiotomy and Perineal Repair

Approval Process

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Acronyms:

DGKH	Directorate General Khoula Hospital
PV	Pelvic Exams
PR	Per Rectum (rectal examination)

Protocol for Episiotomy and Perineal Repair

1. Introduction:

Episiotomy is a common procedures, it is performed by doctor and midwives to widen the vaginal opening to facilitate safe delivery of the fetus

2. Scope

This protocol applies all doctors and midwives working in maternity and child health department at DGKH, who conduct vaginal deliveries.

3. Purpose

The purpose for this protocol to standardize the procedure of episiotomy and perianal repair according to evidence.

4. Definitions

4.1. **Episiotomy**: is a deliberate surgical incision made on the perineum, during second stage of labour to increase the diameter of vulval outlet to facilitate vaginal birth.

5. Protocol:

5.1 There is no evidence for routine Episiotomy, nonetheless is indicated selectively, in some women in labour. Episiotomy is performed when the perineum is thick and inelastic, when Shoulder Dystocia occurs or anticipated in a large for gestational age fetus, during a breech delivery, and when a forceps or vacuum extraction is decided to expedite delivery during second stage.

5.2 An informed verbal consent from the woman is taken after explaining the indication for the episiotomy .Enquiry made regarding any allergies to medications.

5.3 The woman privacy is ensured and she is placed in a lithotomy position.

5.4 The perianal skin is prepared with 1% aqueous betadine or Chlorhexidine

5.5 Suitable site right or left medio-lateral episiotomy is selected.

5.6. A sterile syringe containing local anaesthetic -Lidocaine 1%, should be prepared, the local anaesthetic to be administerd according to the weight of the client (Appendix-1).

5.7 **Technique of infilterating local anaesthetic as the following:**

5.7.1 Place two fingers in between the perineum and presenting part to protect against injury to the fetus.

5.7.2 Insert the needle into the muco-cutaneous junction, at the center of the introitus and direct the needle midway between the right ischial tuberosity and center of the anal canal, if performing a right medio-lateral episiotomy. If performing a left medio-lateral episiotomy then the needle should be directed between the left ischial tuberosity and centre of the anal canal.

5.7.3 Once the needle is inserted into the perineum, before injecting the local anesthetic; withdraw the plunger of the syringe, to ensure that lidocaine is not injected into a blood vessel. If this occurs, blood will appear in the barrel of the syringe and the needle should be repositioned before continuing or discarded. As the lidocaine is being administered the plunger of the syringe should be periodically pulled back to ensure that no blood vessel has been punctured.

5.7.4 Infilterate the perineal tissues in a fan shaped fashion. After administering the local anesthetic, the perineum should be massaged between the finger and thumb to ensure even dispersal of the lidocaine. **Allow 15 min** for the area to be anaesthetized prior to making the incision.

5.7.5 Place the index and middle finger between the presenting part and perineum ,insert the episiotomy scissors between index and middle finger and the perineum at the center of the introitus and directing the points of the blades midway in between the right ishcial tuberosity and the center of the anal canal to avoiding injury to the external anal sphincter.

5.7.6 An incision of approximately 4 cms is made, during an uterine contraction at crowning. (See Appendix 1, fig -1)

5.7.7 The angle of the episiotomy when the perineum is distended during crowning should be 60 degrees from the anal canal. (See Appendix 1-fig-2)

5.7.8 suturing of the Episiotomy is initiated after delivery of placenta, checking its completeness, and no signs of post-partum hemorrhage.

5.7.9 Hemostasis should be ensured during suturing to prevent postpartum hematoma formation

5.7.10. The Episiotomy should be sutured by the Doctor or Midwife who conducted the delivery and performed the episiotomy.

6. Basic Surgical Principles should be followed when performing repair:

6.1. Suture as soon as possible after childbirth to prevent excessive blood loss and to minimize risk of infection.

6.2. Obtain proper lighting

6.3. Explain the procedure to the patient

6.4. Take a verbal and informed consent from the patient

6.5. Check extent of perineal trauma – perform per vaginal and per rectal examination

6.6. Ask for more experienced assistance if the trauma is beyond the operator's scope of practice.

7. Check equipment and prepare the equipment-suture cutting scissors, tooth and non -toothed tissue holding forceps, a needle holder, a sponge holder, two hemostastic artery forceps, and one kidney tray- suture materials -

8. Standard polyglactin 910 (Vicryl)- 2 zero -not totally absorbed from the wound until 60–90 days.– count surgical mops prior to commencing the perineal repair.

9. Ensure wound is adequately anaesthetized with lidocaine (appendix-2), check whether patient experiencing pain, if painful, and readminister the lidocaine

10. Repair should be done under all aseptic precautions.

7. Technique of Repair:

7.1. **Step 1 - Suturing the Vagina:**

7.1.1. Identify the apex of the vaginal wound start repair one centimeters above the apex.

7.1.2. Close the vaginal trauma with a loose continuous stitch

7.1.3. Continue to suture the vagina until the hymenal remnants are reached and re-approximated

7.1.4 At the fourchette insert the needle through the skin to emerge in the center of the perianal trauma

7.2. Step 2 - Suturing the Muscle Layer:

7.2.1. Check the depth of the trauma - it may be necessary to insert two layers of sutures

7.2.2. Continue to close the perineal muscle with a continuous non-locking stitch - taking care not to leave any dead space.

7.3. **Step 3 - Suturing the Perineal Skin:**

7.3.1. At the inferior end of the wound bring needle out under the skin surface

7.3.2. The stitches are placed below the skin surface in the subcutaneous layer - thus avoiding the profusion of nerve endings

7.3.3. Continue taking bites of tissue from each side of the wound until the hymenal remnants are reached

7.3.4. Secure the repair with a loop knot tied in the vagina, the skin sutures should not be too tight.

7.3.4. Minimal use of knots and least amount of suture material promote wound healing and less postpartum perineal pain

7.4 .Step 4-After the Suturing:

7.4.1. Check the finished repair is anatomically correct.

7.4.2. No bleeding is noted.

7.4.3. A rectovaginal examination is done after the repair.

7.4.4. Per vaginal examination - insert two fingers to confirm complete repair and ensure all swabs have been removed.

7.4.5. Per rectal examination – done to ensure no sutures have passed through the rectal mucosa.

7.4.6. Check instruments, suture material and needles used to be discarded in the sharp container, **as per surgical count policy and procedure**

7.4.7. Count mops post procedure and ensure they are correct with the assistant, **as per surgical count policy and procedure**

7.4.8. Document in detailed the following:

A. account of the repair including suture method and materials and mention the count of the number of swabs and mops used was confirmed correct.

B. vitals of the patient and the amount of blood loss.

7.4.9. Observed for 2hours post-delivery in the labour ward again vitals and perineum checked and encourage bladder voiding

7.4.10. Documented before being shifted out of labour room with following advice during postnatal period.

8. Postnatal care:

8.1 Postnatal client should be offered advice about how to care for their Episiotomy or perinea trauma to include the following:

8.1.1 The importance diet and nutrition with adequate fluid intake

8.1.2 The importance of maintain good personal hygiene such as washing their hands before and after attending to perineum hygiene and taking a daily shower or bath.

8.1.3 The importance of physical activity such as walking and performance of pelvic floor muscle exercises

8.1.4 The signs and symptoms of perineum infection, suture breakdown and hematoma

8.1.5 The importance of ensuring that instructions on the timing and dosage of analgesia

8.1.6 The client should be advised that they need to inform their midwife or doctor if their pain does not resolve or increases in intensity, if their vaginal loss becomes offensive, when in patient or after discharge.

8.1.7 The client who have had perineum trauma should be informed that intercourse may be painful at first as this may reassure them that they are not abnormal.

9. Responsibilities:

9.1 **The head of Obstetrics and Gynecology Department shall:**

9.1.2 Emphasize to the consultants /doctors the importance of following this protocol.

9.2. **The Director of Nursing Affairs shall:**

9.2.2. Emphasize to the HoS/Unit Supervisors the importance of following this Protocol

9.3 **The Unit Supervisor of Maternity and Child Health shall:**

9.3.1 Emphasize to all the staff to adhere to the Protocol.

9.**4 The labour Ward In-Charges/Shift In-charges shall:**

9.4.1 Ensure all nurses/midwifes are adhering to the Protocol.

9.5**. All Midwives /Nurses shall:**

9.5.1 Adhere to the Protocol.

9.5.2 Report any incident related the Protocol. .

9.5.3 Liaise with treating team as needed.

9.6 **Treating Doctors shall:**

9.6.1 Adhere to the Protocol.

10. Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Azza Zaid Al Balushi Dr. Mini Mammen Roy	2011
02	Second release	Dr.Reena Mani Dr.Rana Issa	2022

Written by	**Reviewed by**	**Approved by**
Dr.Reena Mani		Dr. Mazin Al-Khabouri

11. Related Documents:

11.1 Surgical Count (Instruments, Sponges, Needles and Sharps) guideline MoH/DGKH/DNA/GUD/031/Vers.02

12. Attachments:

12.1. Appendix -1 Maximum recommended dose of local anesthetic used in Adults:

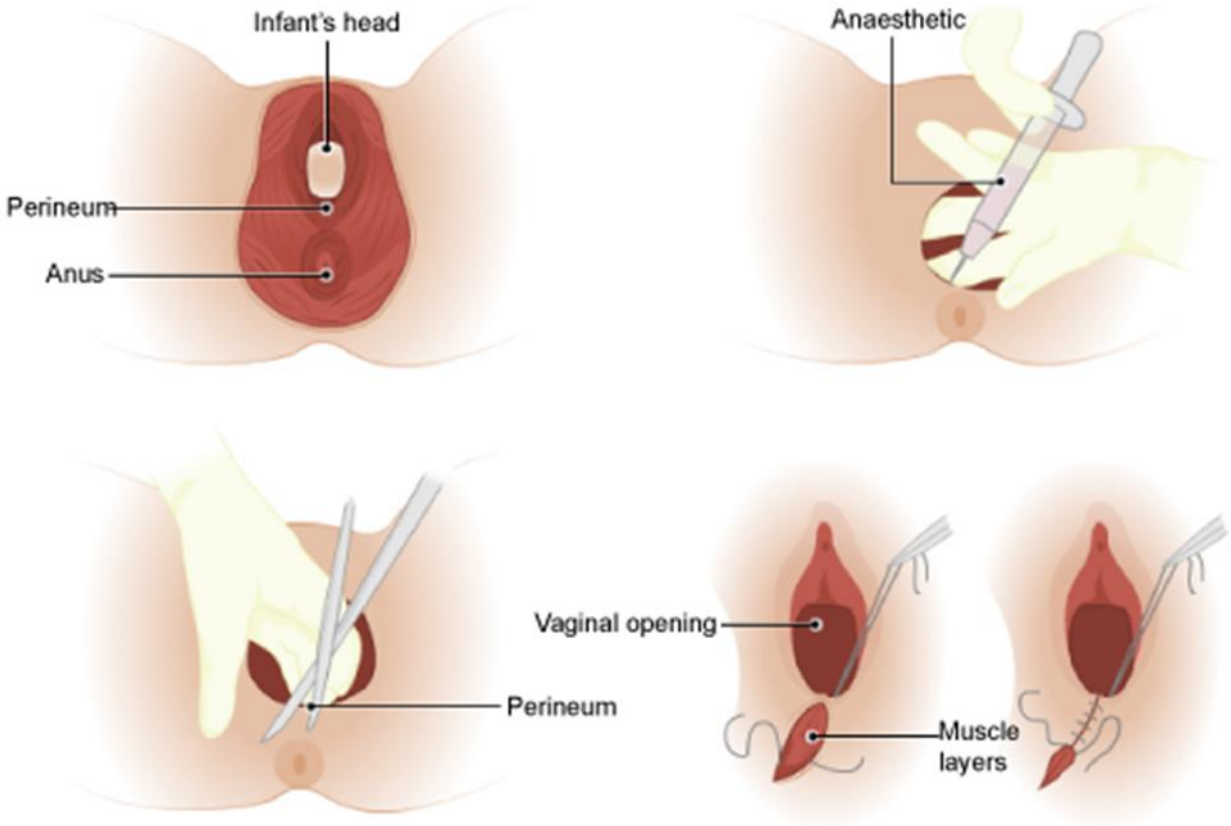
Weight in kg	Maximum volume (ml)	Maximum dose(mg/kg)	Drug
35	10.5	3mg/kg	Lidocaine 1% 10mg/ml
	5.75		Lidocaine 2% 20mg/ml
40	12		Lidocaine 1% 10mg/ml
	6		Lidocaine 2% 20mg/ml
45	13.5		Lidocaine 1% 10mg/ml
	6.75		Lidocaine2% 20mg/ml
50	15		Lidocaine 1% 10mg/ml
	7.5		Lidocaine 2% 20mg/ml
60	18		Lidocaine 1% 10mg/ml
	9		Lidocaine 2% 20mg/ml
70	20 200mg		Lidocaine 1% 10mg/ml

	10		Lidocaine 2% 20mg/ml
80	20 200mg 10		Lidocaine1% 10mg/ml
			Lidocaine 2% 20mg/ml
90	20 200mg 10		Lidocaine 1% 10mg/ml
			Lidocaine 2% 20mg/ml
100	20ml 200mg 10ml		Lidocaine 1% 10mg/ml
			Lidocaine 2% 20mg/ml

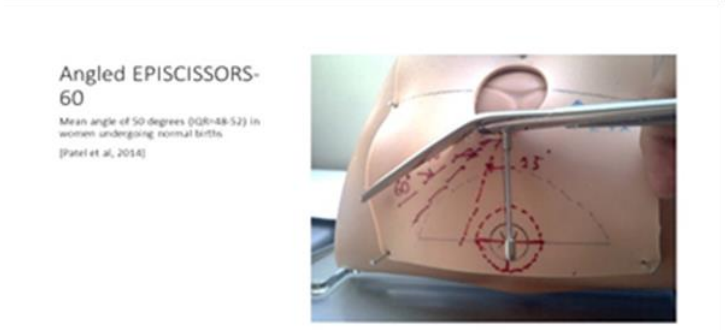
Noted: From 70kg to 100kg, the maximum dose of lidocaine to be infilterated should not exceed 200mg.

12.2 Appendix -2

a.Fig .1



b.Fig.2



13. References:

Title of book/ journal/ articles/ Website	Author	Year of publication	Page
Episiotomy and repair of Perineal tears Diagnosis and Clinical management Croydon www.perineum.net	-Abdul H. Sultan and Ranee Thakar University Hospital, United Kingdom.	2017	
WHO recommendations for interventions during labour and birth	WHO	2018	
Intrapartum Care Guideline	NICE	2015	
Professionals clinical guidelines	NUH	2019	