	Sultanate of Oman Ministry of Health The Royal Hospital Department of Obstetrics and Gynecology

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Title: Management of 3rd and 4th Degree Perineal Tears

01. Incidence - Obstetric and anal sphincter injury is 6.1% in primiparas compared with 1.7% in multiparas (OASIS)

02. Classification of Perineal tears:

First-degree tear: Injury to perineal skin and/or vaginal mucosa.

Second-degree tear: Injury to perineum involving perineal muscles but not involving the anal sphincter.

Third-degree tear: Injury to perineum involving the anal sphincter complex:

Grade 3a tear: Less than 50% of external anal sphincter (EAS) thickness torn.

Grade 3b tear: More than 50% of EAS thickness torn.

Grade 3c tear: Both EAS and internal anal sphincter (IAS) torn.

Fourth-degree tear: Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

If there is any doubt about the grade of third-degree tear, it is advisable to classify it to the higher degree rather than lower degree.

2.1 Rectal buttonhole tear:

If the tear involves the rectal mucosa with an intact anal sphincter complex, it is by definition not a fourth-degree tear. This has to be documented as a rectal buttonhole tear. If not recognized and repaired, this type of tear may lead to a rectovaginal fistula.

3.0 Prediction and prevention

There are few known risk factors for perineal tears, but they cannot be predicted or prevented in all cases. Recognition of risk factors and, if indicted, mediolateral episiotomy angling away from the midline is

recommended

3.1 Risk factors

- Fetal birth weight over 4 kg (2%)
- Persistent occipito posterior position (3%)
- Nulliparity (4%)
- Induction of labour (2%)
- Epidural analgesia (2%)
- Prolonged second stage of labour (4%)
- should dystocia (4%)
- Midline episiotomy (3%)
- Forceps delivery (7%)

4.0 Identification of obstetric anal sphincter injuries

Recognition at delivery is of paramount importance.

Prior to suturing of any genital tract trauma after a spontaneous vaginal delivery, or an operative vaginal delivery, all women should be examined systematically so as to assess the severity of damage.

All skin tears that extend to the anal margin are 3rd degree tears until proven otherwise.

5.0 Surgical techniques

External anal sphincter (EAS) An overlapping or end-to-end (approximation) method can be used, with equivalent outcome.

For partial thickness (all 3a and some 3b) tears, an end-to-end technique should be used

Internal anal sphincter (IAS)-Where the IAS can be identified, it is advisable to repair separately with interrupted or mattress sutures without any attempt to overlap the IAS.

5.1 Repair

a) Should be performed by/under supervision of appropriately trained clinician.

b) All repairs must be conducted in the operating room where there is access to good lighting, appropriate equipment and aseptic conditions.

c) All repairs must be performed under general or regional anesthesia. Muscle relaxation is necessary to retrieve the ends and overlap or oppose without

tension. Repair in labor room may be considered, in selected cases, in consultation with senior obstetrician.

d) The full extent of the injury should be evaluated by a careful vaginal and rectal examination in lithotomy position and the tear should be classified.

e) Consent for repair must include possible complications like flatus and/or fecal incontinence and Recto Vaginal Fistula especially in 4th degree repair.

f) The torn anal mucosa must be repaired with interrupted /continuous 3-0 Vicryl sutures and the knots tied in the anal lumen or a continuous sub mucosal

stitch.

g) When repair of the Internal Anal Sphincter (IAS) muscle is being performed, fine suture size such as 3-0 PDS and 2-0 Vicryl may cause less irritation and

discomfort.

h) The torn ends of the external anal sphincter must be identified and grasped with Allis tissue forceps. The muscle is then mobilized and pulled across to

overlap in a"double-breast" fashion or apposed with 3/0 PDS sutures or vicryl. Partial disruption is repaired by 'end to end' approximation using 3-0 PDS

or vicryl.

i) Great care must be exercised in reconstructing the perineal body and muscles to provide support to the sphincter repair.

Burying of surgical knots beneath the superficial perineal muscles is recommended to prevent knot migration to the skin.

6.0 Post op management

6.1 Immediate -

- Foley's catheter should be left in for at least 24 hours.
- Broad spectrum Intravenous antibiotics & metronidazole to be given intra-operatively.
- Oral antibiotics to be prescribed to complete 7 days of treatment
- All women should be prescribed stool softeners (Lactulose 15 ml BD) for 10 days to 2 weeks to avoid straining and reduce the risk of wound dehiscence.
- Ensure good pain relief with analgesics

6.2 Additional post- operative care.

- Wound hygiene
- Support of perineum during defecation, coughing and sneezing
- Check for any incontinence or bladder retention problems
- Physiotherapy / pelvic-floor exercises. Referral to the Physiotherapist for review and follow up
- Prior to discharge a follow up appointment to be arranged with the Uro Gyn team, 6 –12 weeks after obstetric anal sphincter repair

6.3 Counseling and follow up:

Postoperatively the woman must be given a detailed explanation of the extent of trauma and follow up plan by the parent team

Women should be advised that the prognosis following External Anal Sphincter (EAS) repair is good, with 60–80% becoming asymptomatic at 12 months.

Symptoms to look for at follow up :

- Bowel dysfunction (Flatus, fecal soiling, incontinence or urgency).
- Bladder dysfunction, e.g. retention, incontinence and/or urgency
- Perineal pain
- Sexual dysfunction

If a woman is experiencing incontinence or pain at follow-up, referral to a specialist urogynecologist or colorectal surgeon. As per guidelines an endoanal

ultrasonography and anorectal manometry, if available, should be considered.

A small number of women may require referral to a colorectal surgeon for consideration of secondary sphincter repair.

6.4 Future pregnancy.

Future mode of delivery should be discussed based on the extent of injury and symptoms on follow up. This should be clearly documented in the notes.

Counsel about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery.

The role of prophylactic episiotomy in subsequent pregnancies is not known and therefore an episiotomy should only be performed if clinically indicated. The evidence that episiotomy prevents OASIS and/or anal incontinence is conflicting. However, there is evidence that a mediolateral episiotomy should be performed with instrumental deliveries as it appears to have a protective effect on OASIS. The angle of the episiotomy away from the midline has been shown to be important in reducing the incidence of OASIS

Offer LSCS to women who have sustained an obstetric anal sphincter injury in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry, if available.

Documentation:

- Full operative records. Documentation of the anatomical structures involved, the method of repair and the suture materials should be made.
- Incident reporting.
- Documentation of the counseling session.

7.0 References

RCOG green top guideline 29 - THE MANAGEMENT OF THIRD- AND FOURTH-DEGREE PERINEAL TEARS.

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