Appendix 2 **Third and Fourth Degree Tears – Postnatal Referral Pathway** **Algorithm**	

1. Purpose

This document outlines the procedure details for the management of women who sustain third or fourth degree perianal tears during childbirth at the Women's.

Up to 57% of women with third or fourth degree perineal tears during childbirth suffer from some kind of altered anal symptoms which include faecal urgency and incontinence of flatus, liquid stool and solid stool. This condition may also present in women without obvious anal sphincter tears during labour and delivery (occult injury).

This procedure supports clinical decision making for 3rd/4th degree tears in prevention, diagnosis, initial management, ongoing management and management of subsequent births.

Where processes differ between campuses, those that refer to the Sandringham campus are differentiated by pink text or have the heading **Sandringham campus.**

2. Definitions

Second degree tear: involves trauma to the superficial perineal tissues and involves the muscles of the central perineal body. There is no involvement of the anal sphincter or rectal mucosa. **Obstetric anal sphincter injury (OASI)**: is an acronym used to describe third- and fourth-degree tears.

Third degree tear: injury to the perineum involving partial or complete disruption of the anal sphincter complex (external [EAS] and internal [IAS]). Classification of a third degree tear is dependent upon the degree of disruption as follows:

3a <50% of external sphincter torn[1]

3b >50% of external sphincter torn[1]

3c internal sphincter torn.

Fourth degree tear: involves complete disruption of the external and internal anal sphincter and rectal mucosa.

IRF – Internal Referral Form OP/20

3. Responsibilities

Obstetric medical staff and **midwifery staff** are responsible for the clinical care of the woman.

Physiotherapists are responsible for the physiotherapy management of the woman.

Dieticians are responsible for the dietetic management of the woman.

Pharmacists are responsible for reviewing appropriateness of prescribed medicines, the provision of medicines information and administration information.

CNC Urogynaecology is responsible for initiating follow up care and referral to the Perineal Clinic Team.

Perineal Clinic Team: are responsible for follow-up care and ongoing management of the woman. This team comprises experts in urogynaecology, colorectal, dietetics, midwifery / continence nursing, physiotherapy and sexual counselling. The Perineal Clinic offers a multidisciplinary, best practice approach to the management and follow-up of anal sphincter injury with the aim to prevent/minimise long term complications.

4. Procedure

4.1 Risk factors

The following risk factors have been associated with women sustaining an obstetric anal sphincter injury:

- nulliparity
- Asian or Indian sub-continent ethnicity
- woman has undergone Female Genital Mutilation / cutting (FGM/C)

- baby is large in relation to maternal size (> 4kg)
- previous history of perineal trauma requiring repair
- previous history of obstetric anal sphincter injury
- precipitate or faster than expected second stage
- instrumental birth
- active second stage longer than 1 hour
- inappropriate maternal position (e.g. sustained lithotomy position)
- midline episiotomy or an inadequately angled mediolateral episiotomy which functions like a mid-line.

4.2 Prediction and prevention

Obstetric anal sphincter injury is unpredictable but there are clinical practices which are known to reduce the risk. For this reason all women attempting a vaginal birth should be assessed for their risk of obstetric anal sphincter injury using the Risk Assessment Form contained with the Clinical Information system and management of birth managed accordingly.

- Clinicians must be aware of the risk factors for obstetric anal sphincter injury, but also recognise that known risk factors do not readily allow prediction/prevention of such an injury
- Where episiotomy is indicated, the mediolateral technique is recommended, with careful attention to the angle cut away from the midline
- All clinical staff should follow best practice techniques when making a decision to perform an episiotomy and to perform an episiotomy. Guidance on episiotomy technique is contained within the procedure Episiotomy- Indications and Technique and educational resources are available here. Classification

It is recommended that the classification outlined in the 'definitions' section of this procedure be used when describing any obstetric anal sphincter injury.[1]

If in doubt about the grade of third degree tear, it is advisable to classify it to the higher degree.[1]

4.3 Recognition/identification

It is the responsibility of the accoucher or supervising accoucher to thoroughly examine the perineum after childbirth. Educational resources are available here.

All women should be examined to assess degree of perineal/vaginal/rectal injury after vaginal birth as follows:

- The external anal sphincter should be palpated between two fingers – one vaginal, one rectal
- All women who have an instrumental birth, or who have extensive perineal injury should be examined by a consultant or registrar trained in recognition and management of perineal tears 1
- The assessment and grade of the tear is documented in MCIS (GE), progress notes and operation notes in (ORMIS) if undergoing surgery in theatre.

4.4 Repair technique for third/fourth degree tears

- Extensive tears and all third and fourth degree tears are to be repaired under general or regional analgesia (optimally in the operating theatre).[1] Muscle relaxation is required to retrieve and overlap the retracted ends of the muscle without tension
- Unless repaired under general anaesthesia, a midwife will remain with the woman during the repair to provide emotional support[2]
- If there is a delay in access to the operating theatre of greater than 1 hour *after transfer to theatre* (e.g. holding bay) and the woman and baby, partner / support person are separated, the woman and partner/ support persons are to be kept informed and made aware of any delays.
- A consultant or Level 5 or 6 registrar with experience in third/fourth degree tear repair must be present.[1] Repair must not be attempted by junior medical staff without appropriate supervision[2]

- Prophylactic antibiotic is to be prescribed and administered as determined by the Surgical Antibiotic Prophylaxis Guideline A repeat examination is to be performed in theatre to adequately grade the tear.
- A torn anal epithelium is repaired using interrupted 2-0 Vicryl (polyglactin) sutures with the knots tied in the anal lumen
- Torn ends of the external anal sphincter are fully mobilised and repaired using an overlap technique. If the sphincter is only partially torn (<50%) then repair using an end-to-end technique with interrupted mattress sutures is acceptable. 2-0 PDSII (Polydioxanone) is the preferred suture material. Avoid using 'figure-of-eight' sutures unless for haemostasis, as end-to-end technique may be more vulnerable to ischaemia due to retraction of apposed sphincter muscles[1]
- The internal anal sphincter is identified and if torn, must be repaired separately with interrupted 2-0 PDSII (Polydioxanone) sutures using end-to-end or overlap technique
- If the rectal mucosa is disrupted then this must be repaired using 2-0 Vicryl (polyglactin) sutures for interrupted sutures, or 2-0 PDSII (Polydioxanone) if submucosal continuous sutures are used
- The perineal muscles and subcutaneous tissue are repaired with 2-0 Vicryl (polyglactin). The perineal muscles must be reconstructed with care in order to provide support to the sphincter repair. A short, deficient perineum will increase the risk of further damage in a subsequent vaginal birth. Ensure that the knots are completely buried to avoid suture migration[2]
- The perineal skin is approximated with a subcuticular or interrupted polyglactin suture
- A rectal examination must be performed at the end of the repair, to ensure the integrity of the repair.
- The repair assessments must be documented in the woman's medical record / ORMIS - operation notes.

4.5 Post-operative/postnatal management

All 3rd and 4 Degree Tears

The risk of urinary retention is increased in women who sustain severe perianal trauma due to the pain and oedema around the urethral region. This can be mitigated by leaving the indwelling catheter (IDC) in situ for 24 to 48 hours (or longer) as guided by clinical assessment of the degree of pain and oedema present.

A trail of void must be attended after removal of the IDC. Refer to the guideline Bladder Management- Intrapartum and Postpartum for further information.

Prior to discharge from hospital the woman must be fully informed about the nature of her injury. This includes debriefing of her birth experiences and discussion of the benefits of attending follow-up.

The medical debrief consult will occur within 24-48 hours of birth and be undertaken by a senior clinician as follows:

- Monday to Friday – it is the responsibility of the maternity home team registrar
- Saturday / Sunday - it is the responsibility of the senior weekend obstetric registrar covering postnatal wards.

The consultation will be documented in the woman's medical record and discharge summary.

Guidance on key discussion points can be found in Appendix 3. Appendix 3: Outline and Guide for Clinical Debrief / review.

- It is the responsibility of the covering obstetric team consultant and the obstetric staff consultant to facilitate and support the senior registrar to undertake the medical debrief.
    - The Urogynaecology Fellow / consultant is available for a secondary consult or advice as required.

In addition all women are to be:

- provided with written consumer information and discussion of same – Appendix1.

where applicable, the woman's partner or support person should be encouraged and permitted to stay overnight to support the woman and aid in the parenting care of the baby.

- assessed by a physiotherapist to recommend an individualised program for commencing a pelvic floor muscle rehabilitation program as soon as comfortable, (usually within 24-48 hours following IDC removal). The physiotherapist will ensure correct pelvic floor contraction and understanding.

Specific management for women with a 3C or 4th degree tear

All women with 3C and 4th degree tears must have an in-patient consult with a dietician.

All women with 3C and 4th degree tears must be commenced on a low residue diet for 7 to 10 days with a stool softening laxative. The purpose of this is to delay and reduce the volume of bowel action but ensure soft and easy to passage of stools.

All women with 3rd and 4th degree tears must be given the opportunity to attend a post-natal class session appointment. This is to be made for 2-3 weeks post discharge and where possible, the appointment is to be given to the woman before discharge.

Dietician review is also available at this session to advise women if they have dietary concerns or are experiencing faecal incontinence or constipation.

Perineal clinic referral and follow-up

Parkville

Refer all women to Women's Perineal Clinic to ensure follow up appointments are made with the Perineal Physiotherapist and Urogynaecologist.

- The Continence Nurse will arrange the clinic appointments as per regime.
- The Internal Referral Form OP/20 is to be completed by requesting clinic (midwife / doctor). See Appendix 2 .

Sandringham Campus

- Review women who sustain a 3A or 3B tear at the Caulfield clinic.
- Review women who sustain a 3C or 4th degree tear at the Parkville clinic.

4.6 Medicine measures include:

- Ice therapy, to decrease swelling and pain:
  - Apply an ice pack in a sanitary pad to the perineum for 20-30 minutes every 2-3 hours.
  - Women are shown how to do this correctly to decrease risk of ice burn.
- Adequate analgesia such as non-steroidal anti-inflammatory drugs and, oral paracetamol.
  - Avoid analgesics that can cause constipation
- Avoid rectal analgesia
- Stool softeners (e.g. docusate 120mg bd) are advisable for 7-10 days to avoid constipation and reduce the incidence of wound dehiscence.
  - If constipation occurs, lactulose is recommended.
- Adequate fluid intake (1.5-2L per day), especially if lactulose is required.

4.7 Subsequent management

Woman are advised to commence pelvic floor muscle exercise regime as soon as comfortable, usually within 24-28 hours of IDC removal. This is to ensure the ability to recruit pelvic floor muscles for long term rehabilitation.

Follow up review for all women who sustain an OASI is organised as follows:

1. 2 weeks post birth- Physiotherapy / Dietitian Review –

An appointment is to be made for the woman to attend a post-natal physiotherapy out-patient class at

approximately 2-3 weeks post birth. Women have the opportunity to liaise with the physiotherapist individually and ask questions of a dietician at this time to assess progress.

2. 6 weeks post birth - Perineal Clinic Physiotherapy review.

Ongoing physiotherapy/dietitian appointments and review is determined by the woman's needs.

3. 12 weeks post birth - Perineal Clinic Medical (urogynaecologist) review.

Ongoing appointments and review is then based on the woman's needs.

The Perineal clinic appointments are coordinated by the Perineal Clinic Coordinator.

Where women are required to see multiple clinicians, appointments are to be coordinated so that they occur on the same day and at adjacent times (where possible), to optimise patient time and to minimise the woman's physical examinations.

4.8 Planning the next birth

All women who sustained an obstetric anal sphincter injury in a previous pregnancy must be counseled, at the booking visit, regarding the safest mode of birth based on the degree of trauma and severity of ongoing morbidity. This must be clearly documented in the medical record.

All women who sustained a third/fourth degree tear in a previous pregnancy must be counselled about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal birth/birth[1]. They are also advised that there is no evidence to support the role of prophylactic episiotomy in subsequent pregnancies.[1]

4.9 The role of learners (accouchers) and women with previous sphincter injury

All women who sustained a third/fourth degree tear in a previous pregnancy who are eligible for a vaginal birth, must be cared for and supported during birth by a skilled accoucher. It is especially important that the accoucher provides appropriate control of the emerging fetal head. It is inappropriate for the accoucher to be a student, a graduate midwife or a junior medical officer, even under supervision. However, these clinicians may participate in the woman's labour care.

5. Evaluation, monitoring and reporting of compliance to this procedure

Compliance to this guideline or procedure will be monitored, evaluated and reported through clinical incident reporting.

6 monthly audit of medical records to determine debrief has occurred by a senior clinician and documented accordingly.

6. References

1. Royal College of Obstetricians and Gynaecologists (RCOG). Green-top Guideline No. 29: The management of third- and fourth-degree perineal tears. 2007. pp.1-11.

   http://www.rcog.org.uk/womens-health/clinical-guidance/management-third-and-fourth-degree-perineal-tears-green-top-29

2. Sultan AH (2005) Management of 3rd & 4th degree tears: Labour Ward Guidelines. Mayday Urogynaecology and Pelvic Floor Reconstruction Unit, Mayday University Hospital, UK. 2009.

7. Legislation/Regulations related to this procedure

Not applicable.

8. Appendices

Appendix 1: Refer to the Women's consumer fact sheet: perineal tears – third and fourth degree

Appendix 2 Third and Fourth Degree Tears: Postnatal Referral Pathway – algorithm

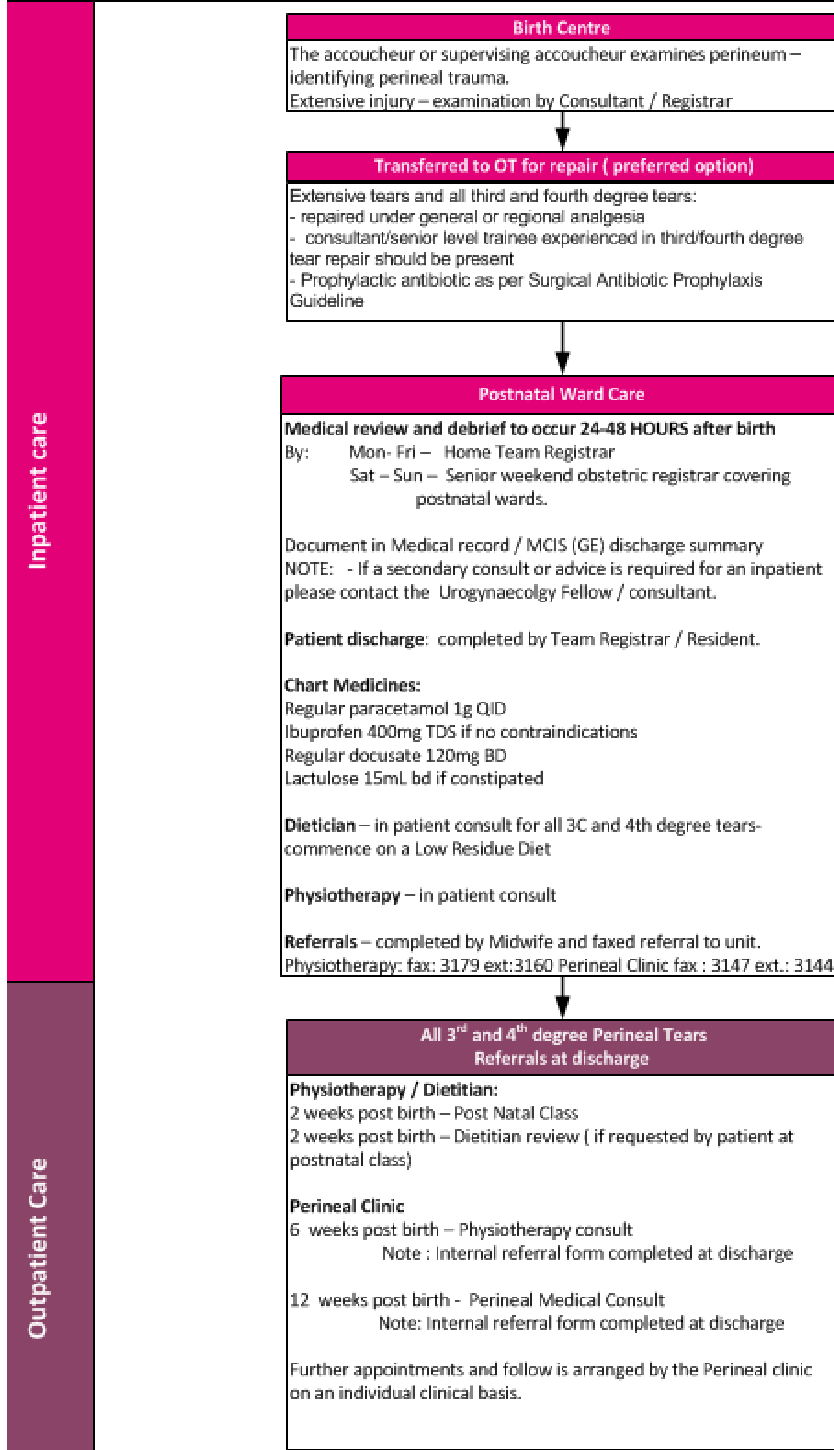
Appendix 3: Outline and Guide for Clinical Debrief / review.

Published: 27 March 2017

The policies, procedures and guidelines on this site contain a variety of copyright material. Some of this is the intellectual property of individuals (as named), some is owned by The Royal Women's Hospital itself. Some material is owned by others (clearly indicated) and yet other material is in the public domain.
Except for material which is unambiguously and unarguably in the public domain, only material owned by The Royal Women's Hospital and so indicated, may be copied, provided that textual and graphical content are not altered and that the source is acknowledged. The Royal Women's Hospital reserves the right to revoke that permission at any time. Permission is not given for any commercial use or sale of this material.
No other material anywhere on this website may be copied (except as legally allowed for under the Copyright Act 1968) or further disseminated without the express and written permission of the legal holder of that copyright.
Advice about requesting permission to use third party copyright material or anything to do with copyright can be obtained from General Counsel.

Third and Fourth Degree Tears – Postnatal Referral Pathway

Algorithm



Appendix 3 **Outline of Clinical Debrief / Consult**	

Postnatal Debrief and Review refers to both in-patient and out-patient care / consult.

The purpose of the post-birth review is to:

- Debrief with the woman (and partner) regarding the birth, the course of events and reasoning behind decisions made, the operative procedure and the post-operative course to date
- Examine the operation site / wound
- Undertake a pain assessment
- Check and explain results of any investigations undertaken and develop on going management
- Assess voiding / bowel habit and manage accordingly
- Provide the woman with the opportunity to ask questions about the procedure / what to expect in the future
- Determine the appropriate clinic follow up / referrals and explain the differences in speciality services and the need to attend
- If required, consult with the urogynaecologist for ongoing treatment plan / and or review.

In some situations further investigations / internal referral to a subspecialty may be necessary.

Examples of referrals:

a) Dietitian – if fecal incontinence
b) Physiotherapy - e.g. problems with bladder, bowel, or sexual function, pelvic floor muscle rehabilitation.
c) Mental health / counselling / sexual health
d) If the pain is not improving / is inconsistent with the post-operative course
e) If symptoms are not resolving as per expected clinical course.

- Ensure written communication to the woman's GP

The aim is to hand over the responsibility or ongoing care to the GP or to make specialist referrals as required.

- ***Documentation of the consultation must be made in the medical record / MCIS (GE), discharge notes/BOS discharge.***