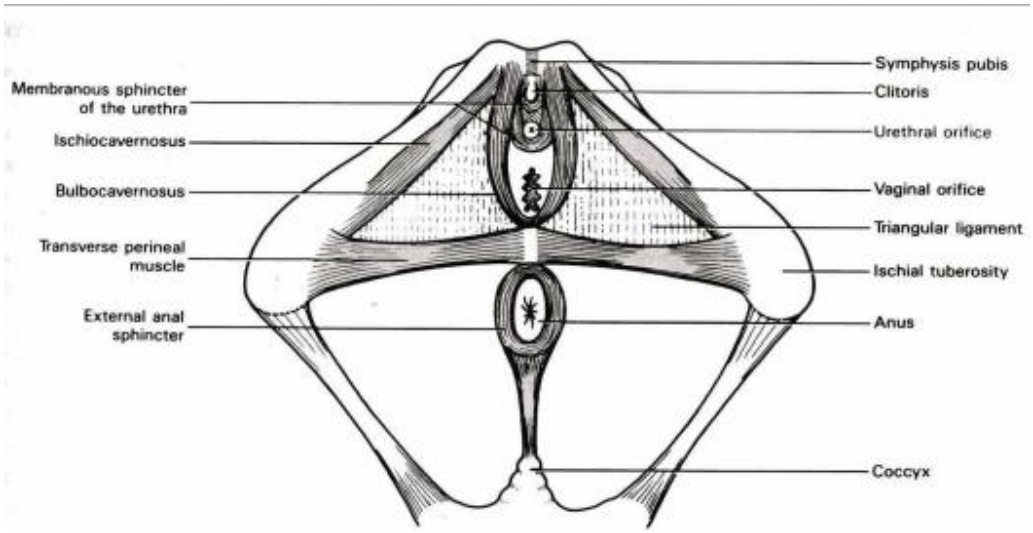
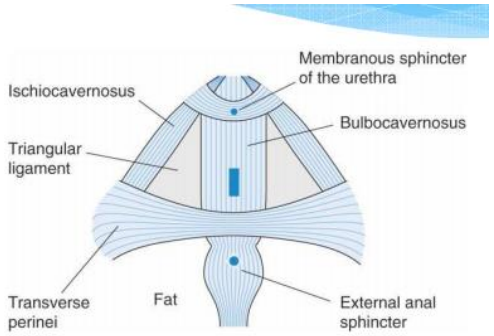
THE PELVIC FLOOR, EPISIOTOMY AND PERINEAL REPAIR AND VAGINAL/RECTAL MEDICATIONS

MID2010

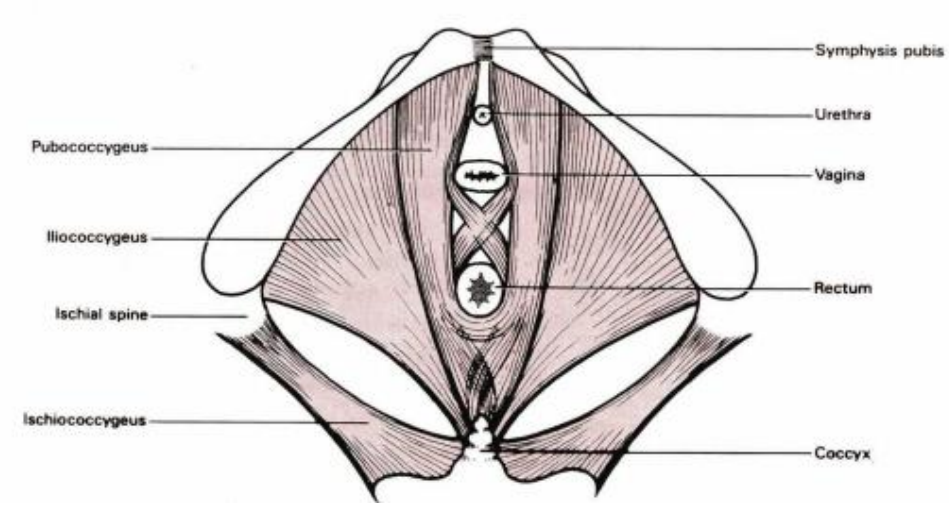
LEARNING OBJECTIVE 1 - REVIEW THE ANATOMY OF THE PELVIC FLOOR

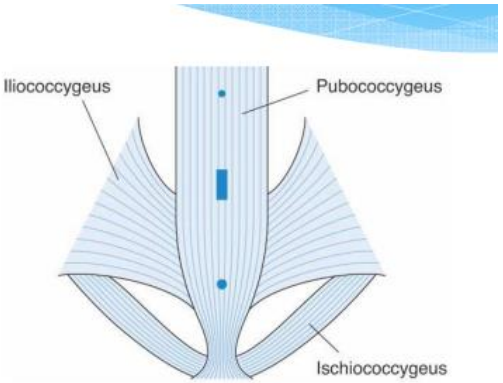
Superficial layers – cavernosus

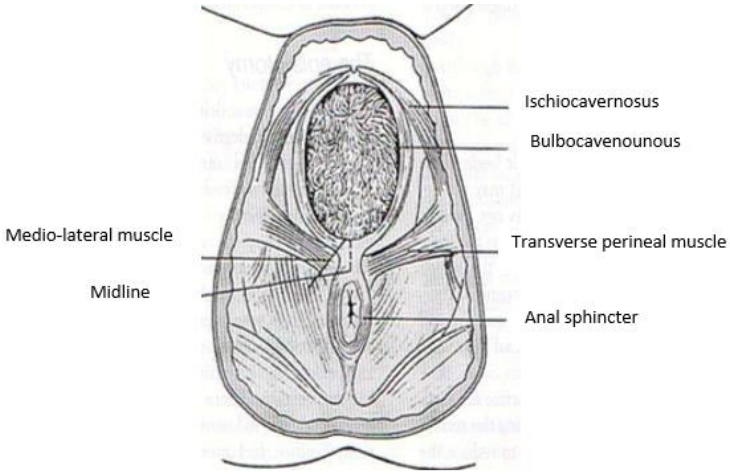




Deep layer – Coccygeus







LEARNING OBJECTIVE 2 - DISCUSS PREVENTION OF PERINEAL TRAUMA

Risk factors:

- Large baby >3.5kg
- Assisted vaginal birth
- Asian ethnicity
- Primigravida
- Episiotomy
- Lithotomy position
- Epidural (due to increased risk of instrumental birth)
- Prolonged second stage
- Malposition
- Forceps birth

Prevention of perineal trauma:

- Perineal massage
- Position upright or lateral when birthing
- Warm packs to perineum
- Women to follow own urge
- Some control of the fetal head during birth
- Birth with a midwife
- Avoid unnecessary episiotomy and instrumental birth
- Avoid epidural
- Giving birth in a home-like environment or at home
- Continuous support

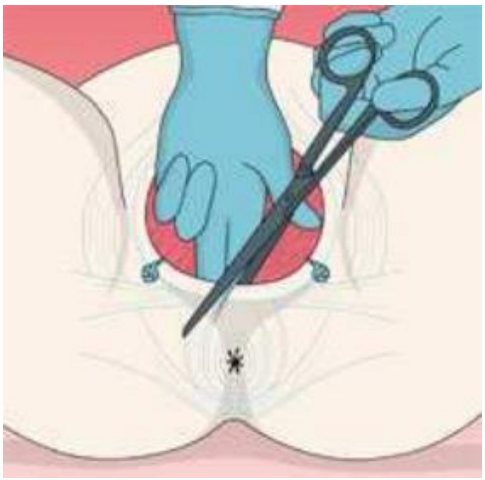
LEARNING OBJECTIVE 3- DISCUSS OBSERVATIONS THAT INDICATE NEED FOR EPISIOTOMY

Episiotomy:

- Not routine procedure
- Medio-lateral preferred to midline
- Same tissues as for 2nd degree tear but can extend

Indications –

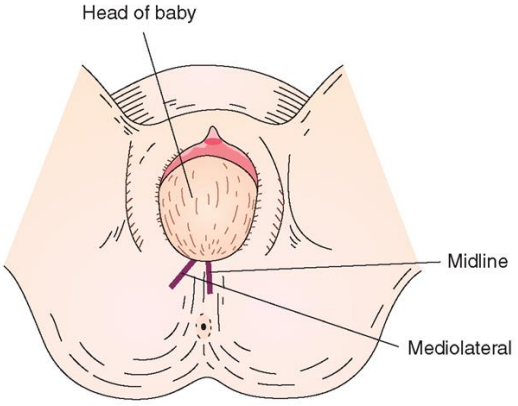
- Fetal distress
- Instrumental birth
- Perineum rigid, not stretching (possible **button holing**)
- Previous severe perineal trauma



LEARNING OBJECTIVE 4 - DIFFERENTIATE BETWEEN MEDIOLATERAL AND MEDIAN EPISIOTOMY INCISIONS AND THEIR INDICATIONS

Midline –

- Incision is made in the middle of the vaginal opening, straight down towards the anus
- Advantage: easy to repair and less painful and less likely to cause pain during sexual intercourse and less blood
- Disadvantage: increased risk of a tear extending into or through the anal muscles which can cause fecal incontinence

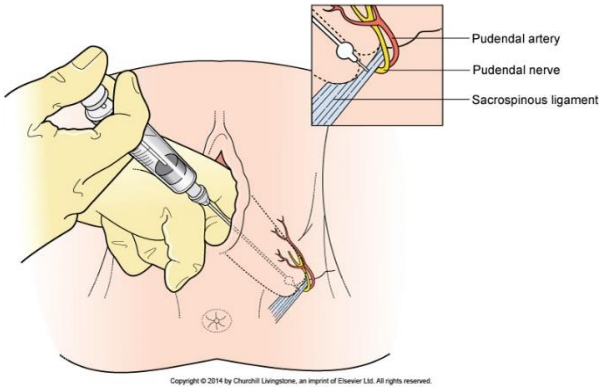


Mediolateral –

- Incision begins in the middle of the vaginal opening and extends down toward the buttocks at a 45° angle
- Advantage: reduced risk for anal muscle tears
- Disadvantage – more painful, increases blood loss, difficult repair

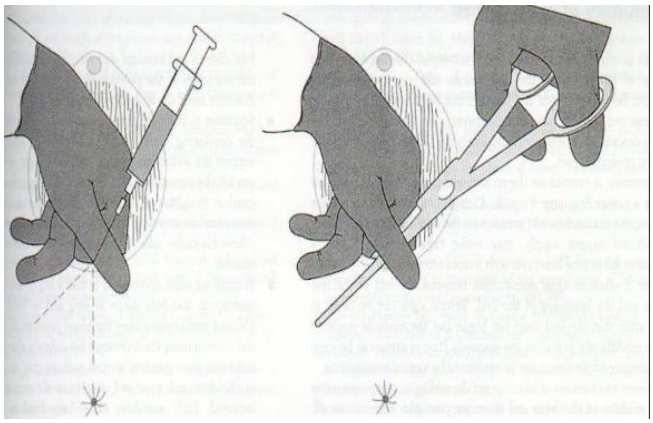
LEARNING OBJECTIVE 5- OUTLINE CONSIDERATIONS WHEN INFILTRATING THE PERINEUM

- Adverse reactions →
  - CNS - lightheadedness / confusion
  - Cardiovascular – hypotension, arrhythmias
  - Neurological - persistent anesthesia
  - Allergic reaction - anaphylactic shock
- Interactions → beta blockers – propranolol, antacids, cimetidine
- Passes into breast milk but in low doses
- Infiltrate in a fan like movement to ensure adequate coverage
- Can cause toxicity in newborn



LEARNING OBJECTIVE 6 - DISCUSS THE PROCESS OF CUTTING AN EPISIOTOMY

- Informed consent
- Local anesthetic – perineal infiltration
  - Lignocaine Hydrochloride 1%
  - infiltration of perineum (10mL)
  - Check policy of maternity unit
- Between contractions draw up local anaesthetic
- Perineal infiltration with local anaesthetic → inject a little bit, move out slightly, inject a little bit → fanning motion
- Place fingers inside vagina between wall and foetal head
- Cut at a 45° angle → mediolateral



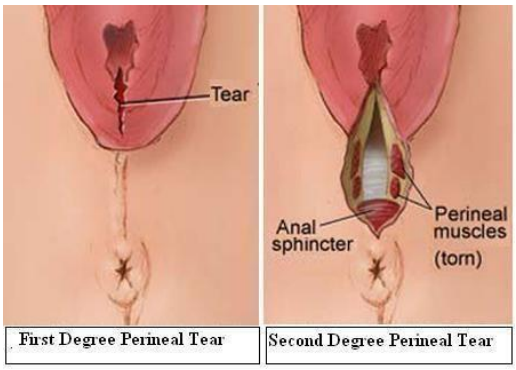
Risks:

- **Maternal**
  - Extension – 3rd /4th degree tear
  - Increased blood loss (PPH is possible from perineal trauma)
  - Increased risk of infection
  - Increased postnatal pain & discomfort
  - Psychological
  - Incontinence
  - Dyspareunia
- **Neonatal**
  - Lacerations
  - Castration (breech)
  - Lignocaine toxicity

LEARNING OBJECTIVE 7 - DEFINE DIFFERENT DEGREES OF PERINEAL TEARS, AND THEIR POTENTIAL COMPLICATIONS

1st degree

- Injury to perineal skin and vaginal mucosa only



Complications: *infection, pain, burning on urination*

2nd degree

- Injury to perineum involving perineal muscles but not involving the anal sphincter

Complications:

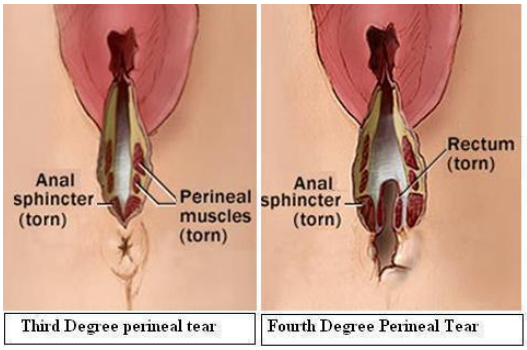
3rd degree

- Injury to perineum involving the anal sphincter complex

3A: Less than 50% of external anal sphincter (EAS) thickness torn

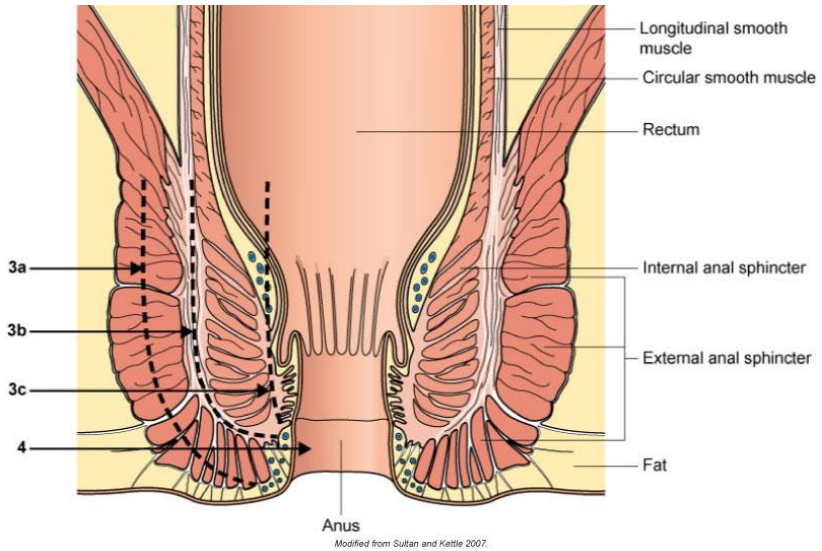
3B: More than 50% of EAS thickness torn

3C: Both external and internal anal sphincter torn



4th degree

- Injury to perineum involving the anal sphincter complex and anal epithelium



LEARNING OBJECTIVE 8- DISCUSS CONSIDERATIONS MADE IN SUTURING A TRAUMATISED PERINEUM

- Suturing material depends on type of tear
- Before suturing ensure no rectal or internal vaginal trauma

LEARNING OBJECTIVE 9 - DESCRIBE THE CARE OF A WOMAN FOLLOWING PERINEAL TRAUMA.

H	**Hygiene** → keep clean and dry → helps prevent infection and promote comfort
I	**Ice/cold packs** → first 24-72 hours for 10-20 minute intervals → helps with swelling and pain
P	**Pain relief** → regular pain relief
P	**Pelvic floor muscle exercises** → gentle PFE within 24 hours to promote healing (depends on tear, consult physio)
S	**Support** → at all times, written and verbal information on perineal care and supportive underwear

Also: Suturing, provision of stool softeners or laxatives, provision of Ural to reduce acidity of urine or encourage to void in the shower, IDC care and monitor and assess for infection

3rd and 4th degree tear specific:

- Infection prevention → prophylactic antibiotics and good hygiene
- IDC → to remain in situ for 12 hours or until swelling has subsided
- Bowel care → laxatives, healthy diet and adequate fluid intake
- Referrals → Physio and a dietician
- Comfort and care → IDC for min 24 hours and encourage twice daily perineal showers
- Medications → avoid rectal suppositories and codeine (can cause constipation)
- Follow up care with GP and Physio

All women having a vaginal birth:

- examined systematically post birth by a midwife or doctor trained and competent in the identification and classification of perineal trauma.
- The timing of the examination should not interrupt mother infant bonding unless the woman has bleeding requiring urgent action
- Prior to suturing, where any degree of trauma requiring repair is identified, a rectal examination must be performed to exclude an anal sphincter tear. The external anal sphincter is palpated between two fingers - one in the vagina and one in the rectum.