AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for clinicians

Third and Fourth Degree Perineal Tears

Clinical Care Standard

The *Third and Fourth Degree Perineal Tears Clinical Care Standard* lists seven statements that describe the care that women should receive to reduce their risk of a third or fourth degree perineal tear, and to optimise their physical and psychological recovery if a third or fourth degree perineal tear occurs.

1 Information, shared decision making and informed consent

During the antenatal period, a woman is informed about the risk for a third or fourth degree perineal tear. Throughout pregnancy, labour and birth, she is supported to make decisions and provide informed consent for the care she receives.

What this means for clinicians

Throughout pregnancy, provide information and support women who are planning a vaginal birth to make decisions about the care they may receive during pregnancy, labour and birth.

By the third trimester, discuss the potential for a third or fourth degree perineal tear.

Discuss the following points together with the woman:

- The fact that perineal tears are common and most heal well without complications
- The fact that third or fourth degree tears are less common (around 3% of all women who give birth vaginally and 5% of first vaginal births)
- Relevant risk factors for the individual woman, including her obstetric history, noting that it is not possible to predict who will have a third or fourth degree perineal tear
- What can be done to reduce risk according to current evidence
- The possible use of induction of labour, epidural analgesia, instruments, episiotomy and an unplanned caesarean section, and their risks and benefits
- The woman's preference for how she would like to give birth
- Assessment and examination to expect after the birth
- How a third or fourth degree perineal tear will be treated if it does occur, and what can be done to assist recovery and improve outcomes (noting that many woman do not have faecal incontinence).

Midwives providing antenatal care for women with additional risks (for example female genital mutilation or a previous third or fourth degree perineal tear) should arrange consultation with an obstetrician or GP obstetrician.

Decisions about the mode of birth for a woman with a history of a third or fourth degree perineal tear should include consideration of the risks and benefits of a vaginal birth compared with a caesarean section. Discussion should consider current urgency or incontinence symptoms, the degree of previous trauma, the risk of recurrence, the success of the repair, any psychological effects, or the woman's request for a caesarean section.

Provide information in a way that meets the woman's health literacy and cultural needs. Also offer support services, such as interpreter services, or support from an Aboriginal health worker, if needed.

Document the outcome of discussions, and any decisions or preferences, in the woman's healthcare record.

2 Reducing risk during pregnancy, labour and birth

A woman choosing a vaginal birth is offered evidence-based care to reduce her risk of a third or fourth degree perineal tear.

What this means for clinicians

During pregnancy, advise the woman about evidence-based options that may reduce the risk of a third or fourth degree perineal tear, as follows:

During pregnancy:

- Perineal self-massage (or by her partner) after 34 weeks of pregnancy can reduce the risk of third and fourth degree perineal tears
- Pelvic floor muscle training may help women prepare for labour and birth and reduce the risk of third and fourth degree perineal tears. Ensure that the woman understands the correct technique to use and refer her to an appropriate clinician for training, if needed.

During a vaginal birth:

- Applying warm compresses on perineal distention can significantly reduce risk
- Slowing the fetal head at crowning and the birth of the shoulders may reduce risk
- Perineal massage during the second stage of labour may reduce risk, however, the acceptability of this practice to women has not been established.

Prior to birth, the possibility of an episiotomy, forceps, vacuum or an unplanned caesarean section should be explained so that the woman is aware of the risks and benefits, and has the opportunity to ask questions.

The selective use of episiotomy may result in fewer women experiencing a third or fourth degree perineal tear. If an episiotomy is performed, a medio-lateral technique with the incision angle 60° from the midline is recommended. Medio-lateral episiotomy should be offered in instrumental vaginal birth, particularly for nulliparous women.

Perineal tear outcome data should be collected and reviewed regularly at clinical review meetings.

3 Instrumental vaginal birth

When intervention is indicated in a vaginal birth, the choice of intervention is based on the clinical situation, the benefits and risks of each option and discussion with the woman.

What this means for clinicians

When an instrumental vaginal birth is indicated and more than one instrument may be appropriate, the choice of intervention should take into account evidence of the relative benefits and risks of the various instruments, the clinician's skill and the woman's preference.

Instrumental vaginal birth may be indicated when there is:

- Fetal compromise
- A need to reduce the effects of the second stage of labour because of a medical condition
- Slow progress in the second stage of labour, associated with risks to the woman or fetus.

Current guidance from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists (UK) include recommendations regarding the conditions for a safe instrumental vaginal birth.*

Clinicians should discuss with the woman the evidence regarding the risk profiles for both forceps and vacuum-assisted birth, as well as the benefits and risks of an unplanned caesarean section.

Forceps use is associated with increased risk of a third or fourth degree perineal tear and other vaginal trauma compared with vacuum-assisted birth. Both carry a small risk of any neonatal injury, but the nature of injuries differs between instruments.*

During a first vaginal birth where instruments are used, medio-lateral episiotomy (with an incision angle of 60 degrees) reduces the risk of a third or fourth degree tear. Tools to help ensure the correct angle of incision include special episiotomy scissors, such as Episcissors-60, which may assist midwives

* see the full clinical care standard for more detail.

and obstetricians to achieve a post-suturing angle of 40-60 degrees. The protective effect of episiotomy is highest when forceps are used, particularly with a first time vaginal birth.

Additional planning is recommended in case a vaginal birth is not achieved with the initial approach, and the risk of subsequent options should be considered (for example, sequential use of instruments or caesarean section at full dilation).

Early discussion during pregnancy about these possible interventions may help prepare the woman should she face this situation. The discussion and her consent should be documented in her healthcare record.

4 Identifying third and fourth degree perineal tears

After a vaginal birth, a woman is offered examination by an appropriately trained clinician to exclude the possibility of a third or fourth degree perineal tear. A tear is classified using the Royal College of Obstetricians and Gynaecologists classification and is documented in the woman's healthcare record.

What this means for clinicians

After a vaginal birth, offer to examine the woman for a perineal tear. Discuss why examination may be recommended, based on the woman's experience and evidence of perineal injury. Explain what is involved with examination and seek consent for any examination. Document the offer, and any examination conducted, in the medical record.

Offer appropriate pain management and conduct the examination with due respect for the woman's recent trauma. If a tear is suspected or identified on examination of the perineum, further assessment is recommended, including a rectal examination to assess whether the internal or external anal sphincters have been damaged.

Use the Royal College of Obstetricians and Gynaecologists classification to grade the severity of the injury. Whenever possible, ask a second, experienced clinician to be present during the examination to assist with identifying and classifying the tear. If in doubt about the degree of injury, classify the tear to a higher degree. Incorrect classification can result in a suboptimal repair and may increase maternal morbidity in the longer term.

Record the outcome of the examination in the woman's healthcare record.

Classification of perineal tears

The Royal College of Obstetricians and Gynaecologists (RCOG) classifies perineal tears as follows:

- **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.**

Rectal buttonhole tears are not included in the RCOG classification and should be documented separately.

5 Repairing third and fourth degree perineal tears

When a woman has a third or fourth degree perineal tear, it is promptly repaired by an appropriately trained and experienced clinician, in a suitable environment.

What this means for clinicians

Accurate identification and prompt repair of severe perineal tears are important to minimise the risk of infection, blood loss, pain and incontinence, as well as long-term physical, emotional and sexual health consequences for women.

Discuss with the woman, the nature of her injury, the procedure for repair and any risks involved. Provide reassurance regarding her recovery and the expected outcome of the repair. Clinicians who respond in a respectful and dignified manner can improve the woman's experience of care.

Surgical repair should be conducted as soon as possible to minimise the risk of infection and blood loss.

The repair should be performed in a suitable environment with good lighting, sterile conditions and access to appropriate equipment and clinical support. In most cases, the repair should be conducted in an operating theatre. If the labour ward replicates the environmental conditions of an operating theatre, a risk assessment should be conducted to determine whether this is a suitable environment.

The repair should be conducted under adequate anaesthesia, using surgical techniques and materials that are consistent with evidence-based guidelines. A rectal examination should be performed after repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa.

Only appropriately trained and experienced clinicians should repair a third or fourth degree perineal tear. Refer women to an appropriately qualified clinician if required. Registrars should be supervised by a senior clinician, unless they have completed their Assessment of Procedural and Surgical Skills or the equivalent level of credentialing or training for the repair of third or fourth degree perineal tears.

Some women may decline surgical treatment because they do not want to be separated from their baby. Advise the woman whether it is possible for her baby and support person to be present during repair and support her to maintain uninterrupted skin-to-skin contact and breastfeed during the procedure, whenever possible.

The decision to use prophylactic antibiotics should be made on a case-by-case basis, following recommendations in the current *Therapeutic Guidelines: Antibiotic*. Although evidence is limited, prophylactic antibiotics for third and fourth degree perineal tears are recommended, or considered reasonable, in most clinical practice guidelines.

6 Postoperative care

After repair of a third or fourth degree perineal tear, a woman receives postoperative care that includes the opportunity for debriefing, physiotherapy and psychosocial support.

What this means for clinicians

While the woman is in hospital, give her an opportunity to discuss her recent experience with the clinician(s) present during the birth and to ask them questions. Ensure that the woman is given information about her medicines, how to care for her injury at home, what to expect while recovering, symptoms to look out for and who to contact if she has any concerns. Provide information about follow-up care required in the short and long term.

Arrange an appointment with a healthcare professional with experience in pelvic floor health such as a physiotherapist, as well as with a psychologist, or social worker if she is likely to need support or assistance at home.

If this care cannot be provided before the woman leaves hospital, arrange an appointment so she can obtain care soon afterwards.

Ensure that the woman's discharge summary notes the care received and any follow-up required.

7 Follow-up care post-discharge

A woman with a third or fourth degree perineal tear receives individualised continuity of care and appropriate follow-up and referral to optimise her ongoing physical, emotional, psychological and sexual health.

What this means for clinicians

Women who experience a third or fourth degree perineal tear need individualised, specialist follow-up care from clinicians with relevant expertise and experience. In the weeks after birth, ensure that the woman has a follow-up with a clinician who has relevant expertise and is familiar with her medical history, to assess and support the woman's physical, emotional and psychological recovery.

Offer and arrange for post-discharge care in a multidisciplinary perineal clinic or other services appropriate to her clinical needs and injury, such as:

- Clinics that specialise in treating women with a third or fourth degree perineal tear
- Specialist medical practitioners, including obstetricians, gynaecologists or colorectal surgeons
- The GP who will provide ongoing care and referral, if needed
- Clinicians who specialise in pelvic floor function and postnatal rehabilitation for women with a third or fourth degree perineal tear, such as physiotherapists
- Healthcare professionals with specialist expertise providing care to women with third and fourth degree perineal tears, such as midwives
- Nurses with specialist expertise in continence management
- Psychologists with expertise or experience in postnatal mental health or birth trauma.

Any issues that may affect future births, and the woman's concerns about these, should also be considered. Acknowledge that, if the woman's support person or partner witnessed a traumatic birth, it may affect their health and wellbeing. Offer them an opportunity to debrief and refer them for support if required.

GPs and other primary care clinicians will provide health care to the woman after discharge. Ensure that adequate information is recorded in discharge summaries about the birth and the woman's ongoing care needs including monitoring for late onset symptoms or signs of faecal incontinence, dyspareunia, postnatal anxiety or depression, or relationship difficulties, and provide appropriate referral options.

Women with faecal incontinence will need support to effectively manage their condition. As such problems may emerge sometime after birth, inform women that support is available if needed and encourage them to report symptoms.

Advise women that a third or fourth degree tear does not exclude a subsequent vaginal birth. Advise them to discuss future birth planning with a maternity healthcare provider who has experience in caring for women with previous third or fourth degree tears, who can provide counselling about future pregnancies and discuss the woman's preferences.

More resources

The *Third and Fourth Degree Perineal Tears Clinical Care Standard* and other resources can be downloaded from **safetyandquality.gov.au/perineal-tears**.