

## How to Minimise Perineal Trauma at Your Birth and Caring for your Perineum after the Birth of Your Baby



### Maternity Department

## Introduction

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This information booklet has been produced to help you prepare your perineum and pelvic floor muscles for the birth of your baby. This will help to minimise perineal trauma. Caring for your perineum after the birth will enhance postnatal recovery and enable you to enjoy your new baby. The information aims to optimise your health and satisfaction during pregnancy, labour and delivery and during the postnatal period. Sharing your birthing preferences with your midwife during labour and delivery will enable you to feel in control of your experience. The information provided in this document is supported by current research evidence, which is correct at the time of publication.

Approximately eighty five per cent of women sustain some degree of perineal trauma following the birth of their baby. Approximately 65%-75% of women will require stitches to enhance healing (Ismail et al 2013, Willer et al 2014). It is normal to experience some bruising and stretching from a vaginal birth. In the UK approximately 8% women experience a third or fourth degree tear. The incidence is higher for women having their first baby (6.1%) compared with 1.7% in women having subsequent babies (RCOG 2015). Third degree tears are referred to as anal sphincter injuries (OASIS) (Marsh & Rogerson 2011:223). Severe perineal trauma can be prevented or minimised with a good level of knowledge and understanding as to how you can prepare and protect your perineum.

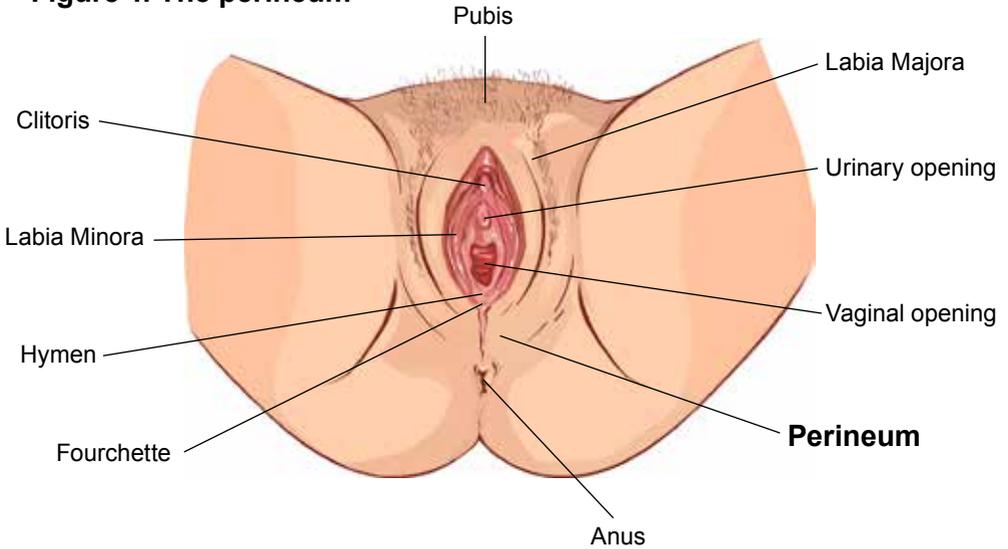
## What is my perineum and pelvic floor?

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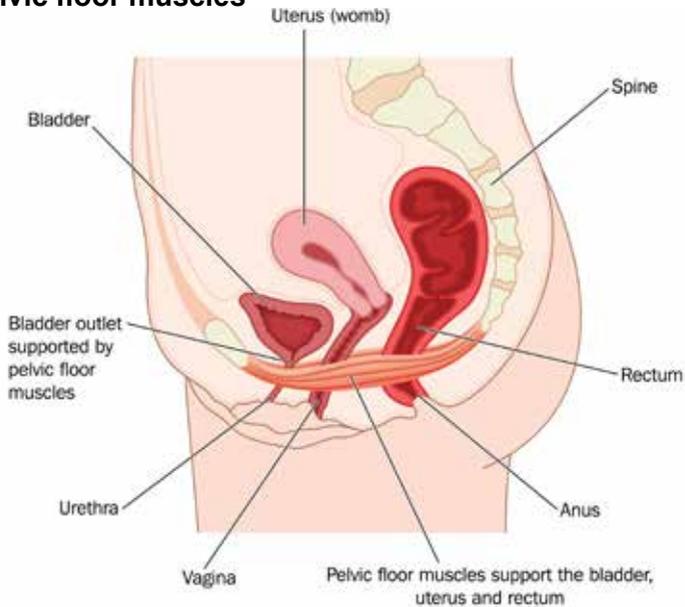
The perineum is the area of tissue between the vaginal opening and anus (back passage) (Fig. 1). It connects with the muscles of the pelvic floor. The pelvic floor is divided into two layers of broad flat muscles that unite in the midline, forming a sling or hammock to support the pelvic organs. Pelvic floor muscles and supporting ligaments are attached to the outlet of your pelvis. These muscles extend from the pubic bone to your coccyx (tail bone) front to back and sideways attached to your sitting bones (tuberosity's). There are three openings, which pass through the pelvic floor. These are the: urethra (opening to the bladder), the vagina (birth canal) and anus (where you open your bowels) (Fig.2).

Pelvic floor muscles have an important function and work most effectively when there is good muscle tone, assisted by pelvic floor exercises. Having a baby can cause muscle weakness, which may lead to stress urinary incontinence, or a dragging sensation in the vagina or rectum caused by a prolapse (drop) of organs in the pelvis from their normal position.

**Figure 1. The perineum**



**Fig 2. Pelvic floor muscles**



## **The functions of your pelvic floor are to:**

- Support the contents of your pelvis – your uterus (womb) and baby, bladder and anus, together with your abdominal organs.
- Maintain continence (control) of your bladder and bowels.
- Support your abdominal muscles when you cough, sneeze, laugh or when lifting.
- Help to support your spine together with your abdominal muscles.
- Play an important role in sexual arousal, enjoyment and performance.

During pregnancy, hormones such as relaxin and progesterone soften the ligaments, which support the pelvic floor helping them to be more elastic and stretchy. During labour it stretches, thins and enables rotation (turning) of the baby's head into the correct position, ready for birth.

## **What is meant by perineal trauma?**

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During birth you may sustain some degree of perineal trauma. Perineal trauma is any damage to the genitalia during childbirth that occurs spontaneously (tears) or intentionally by surgical incision (episiotomy). Anterior perineal trauma (frontal) includes injury to the labia, anterior vaginal wall, urethra or clitoris. Posterior (at the back) perineal trauma is any injury to the posterior vaginal wall, perineal muscles or anal sphincter (muscle which controls your bowels opening and closing). Perineal trauma occurs during spontaneous or instrumental vaginal delivery and may be more extensive following the first vaginal birth. Trauma may also result from prolonged pressure on the perineal nerves during a longer labour.

## Types of perineal trauma

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The types of trauma have been classified as:

- First degree trauma – injury to the perineal skin only.
- Second degree trauma (equivalent to an episiotomy) – injury to the perineal muscles and skin.
- Third degree trauma – involves injury to the anal sphincter muscles, which may or may not involve the perineal muscles.
- A fourth degree tear – more extensive than a third degree tear and involves all of the anal sphincter structure (Adapted from NICE Intrapartum Care 2014).

## Risk factors linked to perineal trauma

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Labour and birth is not always predictable. There are a number of factors, which may lead to perineal trauma. These include:

- Having your first baby because the perineal tissues have not stretched before
- The baby's birth weight over 4,000 gms (8.8 lbs).
- A rapid labour and birth of the baby, as there is not enough time for your perineal muscles to stretch and thin out.
- A prolonged second stage of labour, because your perineal muscles become tired.
- The position of baby at birth that is posterior (baby's back is lying against your back).
- Forceps delivery because of the extra space needed to insert the blades.
- A third or fourth degree tear, extending from an episiotomy.
- An epidural for pain relief because of the associated effects which may lead to an instrumental delivery and episiotomy
- If there is difficulty delivering the baby's shoulders (Shoulder Dystocia) associated with episiotomy (Sultan & Thakar et al 2007).

## What is my likelihood of tearing?

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Each woman will have their own physical differences in the way their perineal muscle fibres stretch. The elasticity of the perineal skin and muscles is dependent on your collagen and elastin structure. As we age we have less collagen. Perineal massage at 34 weeks gestation has shown to reduce the need for episiotomy and stitches in women over 32 years of age having their first baby (Beckmann & Stock 2013).

## Am I at risk of another third degree tear if I have already had one?

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Approximately three to six per cent of women having their first baby may experience a third degree tear because of un-stretched perineal muscles. Each risk factor increases the incidence. Having had a third degree or fourth degree tear does not mean you will automatically have another one. This depends on how well the muscles have healed. An anal ultrasound scan will confirm this. Also, whether you have experienced any symptoms of incontinence since your last birth. You have approximately the same risk as if this was your first birth (Sultan, Thakar et al 2007:44). However, if you have extensive scar tissue or incontinence of wind, or faeces then your chances of a further third degree tear will be increased and you would be advised to have an elective caesarean section (CS) by your consultant obstetrician to protect your perineum.

## What is the risk of anal incontinence after another vaginal birth? Is a caesarean section (CS) necessary this time?

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The decision for a vaginal delivery or caesarean section will depend on a number of factors. These need to be discussed with the Consultant and Specialist Perineal Care Midwife. You will be given information about both types of delivery for you to make a fully informed choice. If you are suffering symptoms of any type of incontinence, or an endo-anal ultrasound scan shows that you have anal sphincter weakness, then you would be advised to have a CS to avoid another third or fourth degree tear occurring. If you have had a previous fourth degree tear your risk of another extensive tear is increased.

## **What is an episiotomy and will I need to have one?**

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An episiotomy is a surgical cut into the perineum made by the midwife or doctor to increase the vaginal opening to make more space for your baby's birth. An episiotomy is only made with your consent and if clinically indicated. The rate of episiotomy in the UK is approximately 8.2% (NHS Maternity statistics 2010-2011). Episiotomy is no longer a routine procedure in the UK and is largely restricted to fetal distress, the need to deliver the baby quickly or need for an instrumental delivery.

## **Will I need another episiotomy if I had one at a previous birth?**

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No. The decision to perform an episiotomy is always assessed at the time of your birth by the midwife or doctor and is also dependent on your wellbeing and that of your baby. If you have had any vaginal surgery, or have extensive scar tissue from a previous episiotomy we may recommend one because scar tissue does not stretch well, and to avoid more extensive trauma.

## **What if I needed to have reconstructive surgery after my last birth will this lead to more perineal trauma?**

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This will depend on the type and extent of reconstructive surgery. Often this is undertaken after an episiotomy wound has not healed properly, leaving problematic scar tissue behind. Surgery aims to remove this scar tissue. There is no reason why your perineum should not stretch well in your next labour and birth. You can make an appointment to see the Specialist Perineal Care Midwife for discussion and perineal assessment. You may be advised to undertake some perineal massage using Vitamin E oil to make the perineal skin softer and more elastic.

## **What if I have had a previous CS and would like a vaginal delivery this time round, will I be at risk of tearing?**

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If this is your first vaginal birth then you will have the same chances of tearing as any other woman having their first baby vaginally. The reasons for your previous caesarean section would need to be taken

into consideration before making a decision with you for your mode of delivery. With good perineal preparation you can minimise your risk of sustaining a perineal tear significantly.

## **Can I have a home birth following a severe tear?**

Having your baby at home in a familiar and relaxed environment will help to minimise perineal trauma and has shown to reduce the incidence of second and third degree tears (Smith & Price et al 2013). Requests for a home birth are always dependent on the health and wellbeing of you and your baby and previous mode of delivery. You can discuss your request with the Consultant and Home Birth Team (Contact Tanya Ashton on **07467339395**).

## **What help is available if I have previously had Female Genital Mutilation (FGM)?**

You will be referred to the Consultant Obstetrician and Specialist Perineal Care Midwife to discuss your options for birth and develop a special care pathway. FGM does not mean that you will have to have a CS. It is possible for you to have your FGM reversed during your pregnancy or labour so that you can have a vaginal delivery. It is probable that you will need an episiotomy to make more space for birthing.

## **Who can I talk to if I am concerned about problems from a previous birth?**

If you have any concerns about a previous birth, or worried about your current pregnancy, labour or birth, you can make an appointment to see the Specialist Perineal Care Midwife in a designated perineal care clinic. You will have the opportunity to discuss your concerns with the midwife and together, develop an integrated perineal care pathway and birth plan. This pathway will be inserted into your hand-held and hospital notes which you can discuss with your midwife so that they are able to support you during labour and birth. You can arrange an appointment through your community midwife, Antenatal Clinic (Telephone: **01483 406717**), GP or you can self-refer to Angie Wilson at **a.wilson12@nhs.net**.

## How can I prepare my perineum during pregnancy?

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There are a number of ways in which you can be pro-active in minimising perineal trauma, pain and pelvic floor problems at your birth and during the postnatal period. Perineal preparation and working in partnership with your midwife during labour and birth does help to reduce the incidence of severe tears (Wilson 2014).

### **Eat a healthy diet with adequate fluid intake**

A balanced diet with polyunsaturated fats plus green and yellow vegetables aids good health, improves perineal blood circulation, and perineal skin elasticity. Vitamin C, found in fresh oranges and red fruits has also shown to increase collagen production, adding strength and regeneration to your perineal muscles before and after birth. Foods high in fibre, a fluid intake of approximately 1.5 litres per day, minimize constipation and the pressure this produces on your anal sphincter muscles. This is particularly important if you have had a third or fourth degree tear previously. Maintaining a healthy body mass index (BMI) 25–29.9 kg/m<sup>2</sup> also reduces the extra pressure placed on the pelvic floor structure. (Nice Guideline 27, 2010)

### **Pelvic floor muscle training (PFMT) and Pelvic Floor Exercises (PFEs)**

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It is important to undertake PFEs to strengthen the pelvic floor, because these muscles play an important role in the birth of your baby. Pelvic floor muscles can weaken during and after childbirth due to extra weight, pressure of the growing uterus and its contents, together with hormonal changes. Weakened muscles may lead to stress urinary incontinence (leakage of urine), a prolapsed bladder or bowel. Because of the lack of strength around the opening to your bladder you may not be able to hold your urine and have an urgency to use the toilet. A weakened anal sphincter muscle may lead to a lack of control passing wind or faeces. Weakened muscles may also affect your sexual satisfaction.

Pelvic floor exercises strengthen muscles and encourage healthy, well-oxygenated perineal tissues, which will stretch more effectively at birth. Intensive pelvic floor muscle training (PFMT) has shown to significantly reduce stress urinary incontinence during the third trimester of the

pregnancy and during the postnatal period. They may also protect you against anal incontinence and are particularly beneficial for women who have delivered a large baby or experienced a previous forceps delivery. (Boyle & Hay-Smith et al 2012). For instructions, please refer to the Patient Information Leaflet – Pelvic Floor Exercises produced by the RSCH Physiotherapy Department. Referral to the Physiotherapist may be needed if you have a history of urinary or anal continence problems.

## **Antenatal Perineal massage**

Massage does not make any measurable difference to the rate of perineal tears. However, it has been shown to make a difference to:

- the incidence of perineal trauma needing stitches
- the rate of episiotomy in women having their first baby and women who have not previously given birth vaginally
- reduce postnatal perineal pain in women having more than one baby (Dame et al 2008, Beckmann & Stock 2013).
- women over 32 years of age because the collagen, which strengthens perineal tissues, diminishes during the aging process
- the elasticity of the pelvic floor muscles, improving blood flow and stretching at birth
- women who have previous scar tissue or rigid perineum – sometimes evident is women who ride or dance regularly.

## **When can I start perineal massage?**

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You can start perineal massage any time from 34 weeks of pregnancy.

## **Instructions for perineal massage**

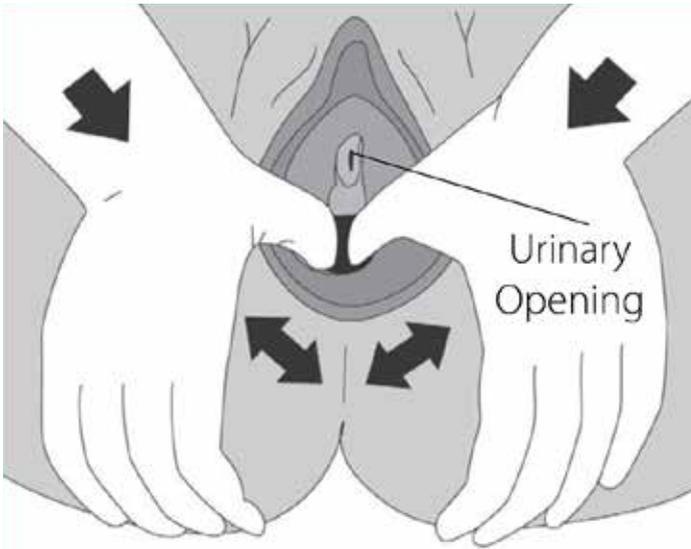
- Yourself or your partner can undertake perineal massage.
- Wash your hands well and keep your fingernails short.
- Relax in a private place, sitting with your knees bent in an upright position. Some women like to lean on pillows for back support.

- It helps to have a bath, shower or warm compress on the perineum first to encourage a good blood supply to the perineal tissues.
- Lubricate your thumbs and perineal tissues. Use a lubricant such as Vitamin E oil or your body's natural lubricants (Avoid nut-based oils if known allergies). Do not use baby oil or petroleum jelly as these may cause skin irritation.
- Place lubricated thumb or thumbs 1 to 1.5 inches inside your vagina (See Figure 3)
- Press down towards the anus and to the sides and hold for about 1 to 2 minutes until a slight stretching, burning sensation is felt, simulating the baby's head birthing
- With your thumbs, slowly massage the lower half of the vagina using a 'U' shaped movement (3-9 o'clock) as shown in the diagram.
- At the same time focus on your relaxation.
- Massage your perineal area slowly for up to 10 minutes once or twice a week only; you will notice the area more stretchy with less burning sensation.
- Massage more than 3 times in two weeks appears to decrease this protective effect (Beckmann & Stock 2013) therefore, less is better to avoid over stimulation and soreness of healthy perineal tissue.
- Gentle massage can be applied to previous scar tissue to help soften and stretch this area.
- The procedure should NOT be painful.
- Your partner can also undertake this massage following the same principles using their index finger. Talk to your partner and advise if it is uncomfortable or painful.

(American College of Nurses and Midwives 2005, Beckmann & Stock 2013, <https://www.youtube.com/watch?v=DK2P8Ziqc6Y> )

Massage should not be undertaken if you have vaginal thrush, a urinary tract infection or genital herpes as these conditions might damage the walls of the vagina until treated. Check with your midwife if you are unsure. Benefits of perineal massage during the second stage of labour are inconclusive.

**Figure 3. Perineal Massage**



### **Can I use perineal stretching devices?**

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Perineal stretching devices have not been included in this booklet as they have been associated with adverse effects. The evidence surrounding this practice is currently being evaluated for effectiveness on perineal outcomes. (Kovacs & Health et al 2004, Ruckhaberle & Jundt et al 2009).

### **Minimising perineal trauma during labour and birth. What are the best positions for labour and birth to reduce trauma?**

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Keeping active and mobile during labour in an upright position will assist gravity and the progress of the baby moving downwards in the birth canal. You need to choose a position that is comfortable for your labour and birth. Leaning forward over the back of the bed or adopting a lateral position (lying on your side) in contrast to a semi-recumbent or lithotomy position for birth has been shown to reduce the need for an episiotomy and reduces the likelihood of third degree perineal tears particularly if this is your first baby. (Shorten & Donsante et al 2002, Baker 2010, RCM 2010, Meyvis & Rompaey et al 2012). Position at birth is your choice. However, you need to be guided by the midwife and the normal progress of your labour (NICE Intra-partum pathway 2014).

## **Application of warm compresses to the perineum during the second stage of labour**

Your midwife or birth partner can be encouraged to apply a warm compress or pad to your perineum during the last part of the second stage of labour and as the baby's head begins to stretch the perineal tissues. A pad or flannel soaked in warm water between 45-59 degrees C (hand warm), wrung out, can be gently placed on the perineum during contractions. The pad should be re-soaked to maintain warmth between contractions. The procedure has also shown to significantly reduce third and fourth degree tears and pain at delivery (Albers 2005, Dahlen 2007, & Aasheim et al 2012:20).

## **Using instinctive pushing to birth your baby**

Your midwife will encourage you to go with your natural urge to push, using spontaneous pushing when your baby is ready to be born. Some women may need some direction with pushing particularly if they have an epidural for pain relief. You will be encouraged to slow the birth of the baby's head at the point of crowning and breathe the head out between your contractions. This practice has been shown to increase the likelihood of an intact perineum, reduce the need for an episiotomy, and reduce the risk of second or third degree tears (Laine & Skjeldestad et al 2012).

## **'Hands on' or 'hands poised' (ready) and perineal support at delivery**

The midwife will be able to work with you to control and slow the birth of your baby's head and shoulders at birth. This is done by the midwife observing the baby advancing, placing gentle pressure on the baby's head if necessary, asking you to pant or breathe slowly as the baby's head crowns (emerges). Supporting the perineum and controlling the birth has been shown to reduce the incidence of severe (third and fourth degree tears) perineal trauma up to 50% (Hals & Oian 2010, Laine & Skjeldestad et al 2012).

## **Restricting episiotomy**

The decision to perform an episiotomy is restricted in the UK and only performed when the midwife or doctor considers the baby or woman's

health is at risk. The risk of an episiotomy extending into a further tear or into the anal sphincter muscle is greatly reduced due to a wider angle of incision being performed when required (Freeman & Hollands et al 2014).

## **Water for labour and birth**

The Royal Surrey Trust Policy recommends 'hands off' the perineum for water births. Birthing in water has not been shown to lead to less overall perineal trauma or improved perineal integrity in the postnatal period. It does result in a shorter second stage of labour. Physical limitations of 'hands on' management in water when you birth your baby may be associated with an increased incidence of third degree tears due to the expulsive nature of the head and shoulders at birth. It may be more advantageous to labour in water and deliver 'on land' particularly if you have a history of a third or fourth degree tear to avoid further trauma (Harper 2000, Cortes & Basra et al 2011: 27). However, the choice is yours.

## **Hypnobirthing**

Hypnobirthing is a state of deep relaxation through a programme of birth education. This enables you to prepare the mind and body through self-hypnosis. Learning breathing and relaxation techniques can enable you to have a more comfortable and positive birth experience. When relaxation replaces the fear of childbirth, your endorphins (nature's natural pain relieving hormones) work with pregnancy hormones to relax all your muscles, including the pelvic floor. Hypnosis during childbirth has shown to decrease labour pain and increase spontaneous vaginal birth (Baker 2014, NICE 2014). For more information on where to find classes please contact: [\*\*sallystainer@nhs.net\*\*](mailto:sallystainer@nhs.net)

## **Assessment of your perineum following the birth**

The National Institute for Health and Care Excellence – Intrapartum care (NICE 2014) recommend that all women having a vaginal delivery should have a thorough assessment of the genitalia and vagina. A rectal examination will also be undertaken to assess the strength and tone of your anal sphincter muscles. This is done to avoid missing a third or fourth degree tear and to reduce short and long term problems. Your consent will be sought to undertake this procedure. (Andrews et al 2006, Sultan & Thakar 2007, Stevenson 2010).

## **Repair of tears and episiotomy**

Leaving first and second degree tears or an episiotomy un-sutured is associated with poorer wound healing and some short-term perineal discomfort (RCOG 2004/8). An episiotomy usually extends into the deeper muscle layer and will require repair. Continuous stitches are inserted into the vagina, perineal muscles and under the skin layer. This method is associated with less short-term pain (Kettle & Johanson 2004). Occasionally, individual stitches are inserted if the tear is more complex. With either method, suture material is designed to breakdown naturally after 7-10 days, causing minimal perineal discomfort in the postnatal period. The benefits of suturing are to minimize infection, re-instate perineal muscle function for future childbirth, maintain good continence and sexual intercourse. Third and fourth degree tears are repaired in theatre under regional or general anaesthetic. It is not uncommon for small tears to occur around the labia or clitoris. Labial tears, if not deep or bleeding and on one side of the vulva only, can be left to heal naturally. If two opposite labial tears occur it is recommended that small absorbable stitches are inserted to prevent the labia sticking together. Tears around the clitoris are repaired in theatre under regional anaesthesia to re-instate nerve sensitivity.

## **What happens if I need to have an instrumental delivery?**

If you need to have a ventouse (small cap to baby's head) or forceps delivery you will need to be in a lithotomy position (semi-sitting/lying) on the bed for easy access. If the baby is distressed and you need a forceps delivery an elective episiotomy will be undertaken to make more space to deliver your baby. Your perineum will be sutured following your birth.

## **Caring for your perineum after the birth of your baby**

Most women will experience some degree of discomfort or pain following a vaginal delivery. This can range from stretching and bruising, an uncomplicated first or second degree tear or episiotomy, to more extensive trauma such as a third or fourth degree tear. There are a number of ways you can help yourself to get comfortable. The midwife is always on hand to give you advice. It is important that you report any pain or discomfort to the midwife so that adequate pain relief can be prescribed. The midwife will assess your perineum alongside individualised postnatal care.

## **The importance of assessment and inspection of your perineum by the midwife**

The midwife will enquire as to any perineal pain or discomfort when they undertake your postnatal check. It is beneficial for you that the midwife inspects your perineum to assess for healing and any signs or symptoms of infection or offensive lochia (blood loss). This assessment should be undertaken either by lying on your side or semi-recumbent (semi-sitting). This will ensure that the midwife can see clearly to undertake a thorough assessment.

## **How can I minimise perineal infection?**

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To minimise the risk of infection and wound breakdown, personal hygiene is very important. Undertaking a daily bath or shower and adopting a good hand-washing technique before and after visiting the toilet and before and after changing your sanitary pad is essential to prevent perineal infection. This is particularly important if you or your family or close contacts have a sore throat or upper respiratory tract infection. You can prevent Group A streptococcus (Strep A) infection in your perineum – a bacteria found on the skin and in the throat. If you feel generally unwell, experience a raised temperature, the perineal wound site is painful, there is swelling, or unpleasant odour you need to contact the midwife or GP urgently. Infection can spread quickly along the genital tract into your general circulation and can be serious, for this reason it is very important that you report symptoms early to the midwife or GP, a perineal swab can be taken and an appropriate antibiotic be prescribed if necessary. In extreme cases you may need to be admitted to hospital (CMACE 2011).

## **Cleansing your perineum**

Bleeding after delivery usually lasts between 2-4 weeks, occasionally longer. Always use plain water to clean your perineum. Cleanse your perineum after each visit to the toilet or when changing your sanitary pad. Leaning forward when you urinate and using a jug of warm water over the vulva can also reduce stinging. The perineum heals best in a moist environment. Hairdryers should not be used to dry the perineum. Use toilet paper to gently pat dry around stitches if you have them. Wearing light breathable cotton knickers also enhances healing. You can minimise infection and promote good wound healing by drinking plenty of

fluids and eating a balanced diet including vegetables and foods rich in vitamin C. Anaemia may slow wound healing. If you have a wound that has broken down extensively and healing is not taking place then you may need to be admitted to hospital for re-suturing.

## **How do I protect my perineal stitches when my bowels are open?**

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Most women feel anxious about having their bowels open when they have perineal stitches especially after a third or fourth degree tear. A high fibre diet with plenty of fluids helps to minimise constipation. You can support your perineum by placing a clean sanitary pad or toilet tissue over the perineum, in front of the anus for support while gently pushing to open your bowels.

### **Relieving perineal discomfort or pain**

‘Cold therapy’ such as cooling perineal gel-pads (Fempad) or ice packs have been shown to be effective in reducing perineal pain, bruising and swelling within the first 48 hours of birth, with no delay in wound healing (Steen 2007, Leventhal et al 2011). Ice packs can be made up very simply by wrapping a small bag of frozen peas in a piece of gauze or thin flannel (to prevent ice burns to your skin) and placed over the perineum. Apply for up to twenty minutes, have a short break and repeat as needed. The Fempad can be purchased online. The Fempad does not freeze, but is cool and comes with disposable covers.

Aromatherapy oils such as lavender, calendula, and tea tree, have antiseptic and antimicrobial properties (Tiran 2000). Geranium and chamomile assist in wound healing and have a pain relieving effect and many women find these oils used in the bath water soothing. However there is little evidence of its effectiveness (Steen 2003). If you wish to use any of these oils you need to consult a midwife who is trained in the use of complimentary and alternative medicines, for your safety. Lavender or T tree oil can be used safely in a peri-bottle. This is a plastic squirt bottle (a water bottle with a pop-up top is effective) that can be used to cleanse the perineal area sitting on the toilet. Always dilute oils before use in base oil. Add 5 drops of chosen oil per 500mls of warm water. If these oils are used in the bath, mix a maximum of 6 drops in some base oil or milk before adding to the bath water.

Homeopathic remedies such as Arnica, is frequently used by women to reduce bruising and stimulate tissue repair. There is no conclusive evidence to support its use currently. Again you need to be guided by a homoeopathist for safe use. Midwives are not permitted to recommend this remedy.

The midwife, when in hospital can provide pain-relieving tablets. Paracetamol or Ibuprofen, an anti-inflammatory, non-steroidal preparation can be given to reduce perineal swelling if not contra-indicated. The later may have been given via suppository in the delivery suite if you have had stitches.

## **What if the pain does not improve or gets worse?**

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If you experience pain that will not go away or gets worse, it is important that you inform the midwife or doctor immediately so that your perineum can be inspected. The pain may be a sign of infection or severe bruising particularly following an instrumental delivery. If you experience extreme pain this may be due to a haematoma (a build up of blood in the perineal tissues). This is an infrequent complication.

## **Finding a comfortable position for feeding**

It is important that you find a comfortable position for feeding and that any perineal discomfort is alleviated before you commence. Lying on your side to feed your baby will take the pressure off your perineum. Rubber or cushion rings should be avoided as these may increase swelling which may delay or prevent healing. Air filled valley cushions have been scientifically designed to aid perineal healing as an alternative to the ring cushion. These can be purchased or hired. [www.valleycushions.co.uk](http://www.valleycushions.co.uk)

## **Managing third or fourth degree tears after birth**

If you have sustained a third or fourth degree tear, this will be repaired in theatre with a spinal or epidural for pain relief. When you come out of theatre you will have a catheter (tube) into your bladder to make urinating more comfortable. You will also be prescribed antibiotics to minimise the risk of wound infection. Laxatives such as lactulose will be prescribed for the first ten days help you have your bowels open more comfortably. As well as your usual postnatal care, you will also be given an eight to

twelve week follow-up appointment with a consultant to assess your perineal muscular strength, comfort and healing. You should also see the physiotherapist prior to leaving hospital and before your six-week postnatal appointment to discuss PFEs. You may also receive an appointment for anorectal and endoanal ultrasound scan investigation to assess the function and anatomy of your anal sphincter muscles. For further information on third and fourth degree tears refer to 'Information for You' A third or fourth degree tear during birth (RCOG 2015b).

## **Postnatal Pelvic Floor Exercises or PFMT**

Continuing with PFEs after birth is important due to over stretching and weakening after pregnancy and birth. Weakened muscles can lead to stress urinary incontinence. Exercises will strengthen your pelvic floor providing support and improve bowel and bladder control. PFEs should be undertaken regularly for three to six months to regain their full strength. Exercises should only be commenced after you have emptied your bladder well after birth and you do not have a catheter. Gentle exercises can also be commenced following a third or fourth degree tear. Exercises need to be continued for life to maintain good pelvic floor strength. Please refer to the leaflet: Postnatal Advice and Exercises Following Childbirth from the physiotherapist.

## **When can I commence sexual intercourse again?**

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Resuming sexual intercourse is dependent on the degree of perineal trauma sustained, your blood loss, healing, and how you feel both physically and mentally. Healing can take between three to four weeks after the birth. You need to give your perineum time for the stitches to bring the muscles together. There is no set time period. Do remember to use contraception! Don't worry if sex feels different at first. You may find it more comfortable using a non water-based lubricant such as SYLK or Replens. After birth, the vaginal canal can be dry due to the readjustment of hormones and breastfeeding. You may need to experiment and alter your sexual positions finding one comfortable for you, for example being on top of your partner or at the side. The emotional changes you experience and the relationship between you, your baby and partner can be very strong after childbirth and can lead to a lack of sexual desire. This is all completely normal.

## What if I have perineal problems following my delivery?

If your perineal wound has not healed or you find intercourse painful, and would like some advice, please discuss with your midwife or GP or make an appointment see the Specialist Perineal Care Midwife. You can also discuss problems you may have experienced regards your perineum with your midwife following your birth.

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## Further information and resources

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### **Vagoga**

An innovative exercise programme for developing and maintaining a strong and healthy pelvic floor. For local classes ante and postnatal please contact: <http://www.vagoga.co.uk/>

### **Vulval Pain Society**

[info@vulvalpainsociety.org](mailto:info@vulvalpainsociety.org)

### **Bladder and Bowel Foundation**

[www.bladderandbowelfoundation.org](http://www.bladderandbowelfoundation.org)

### **Incontinence Foundation**

<http://www.incontinence-foundation.org.uk/>

### **A Third- or Fourth-Degree Tear during birth**

‘Information for you’

<https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-third--or-fourth-degree-tear-during-birth.pdf>

### **Female Genital Mutilation**

<http://www.desertflowerfoundation.org/en/>

## Contact details

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For further information please contact:

### **Dr Angie Wilson – Specialist Perineal Care Midwife**

Royal Surrey County Hospital  
Egerton Road, Guildford, Surrey GU2 7XX

**Email:** a.wilson12@nhs.net

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## PALS and Advocacy contact details

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Contact details of independent advocacy services can be provided by our Patient Advice and Liaison Service (PALS) who are located on the right hand side as you enter the main reception area. PALS are also your first point of contact for health related issues, questions or concerns surrounding RSCH patient services.

**Telephone:** 01483 402757

**Email:** rsc-tr.pals@nhs.net

**Opening hours:** 9.00am–3.00pm, Monday to Friday

If you would like information documents in large print, on tape or in another language or form please contact PALS.

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