NHS
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How to minimise perineal trauma at your birth and caring for your perineum after the birth of your baby

Maternity Department

Patient information leaflet

Introduction

This information booklet has been produced to help you prepare your perineum (area between vagina and anus) 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 help postnatal recovery and enable you to enjoy your new baby. The information aims to improve your health and satisfaction during pregnancy, labour and birth and during the postnatal period. Sharing your birthing thoughts with your midwife during labour and birth will help you to feel in control of your experience. The information provided in this booklet is supported by research evidence.

Approximately 85% of women will have some degree of perineal trauma following the birth of their baby. Approximately, 65% of women will need stitches to help healing (Frohlich et al 2015). It is normal to experience some bruising and stretching from a vaginal birth. Third or fourth degree tears also known as anal sphincter injuries (OASIs) occur in approximately 2.9% of women having vaginal births in the UK (between 0-8% women), (Thiagamoorthy et al 2013). This happens in approximately 6.1% of women having their first baby compared to 1.7% in following births (RCOG 2015). 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. Your midwife and obstetrician will also help to minimise perineal trauma at your birth.

What is my perineum and pelvic floor?

The perineum is the area of tissue between the vaginal opening (birth canal) and anus (back passage where you poo) (Fig. 1). It connects with the muscles of the pelvic floor. The pelvic floor is divided into two layers of muscles, forming a sling or hammock to support the pelvic organs. 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 and anus (Fig. 2).

Pelvic floor muscles have an important function during birth and work best when there is good muscle tone, helped by pelvic floor exercises. Having a baby can cause your muscles to become weak, which may lead to stress urinary incontinence (some leaking of urine), or a dragging sensation in the vagina or rectum caused by a prolapse (slight drop) of organs in the pelvis from their normal position.

Fig 1. The perineum

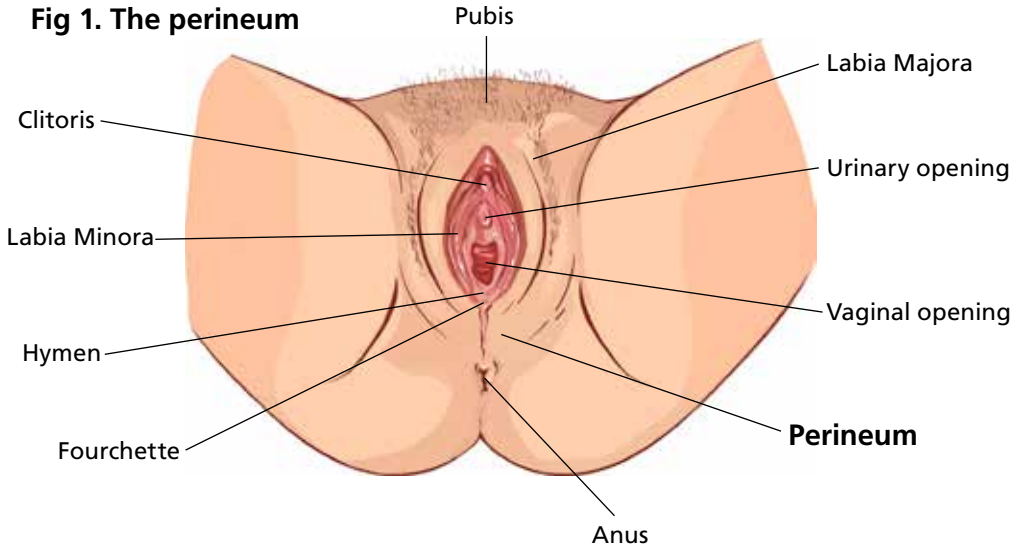
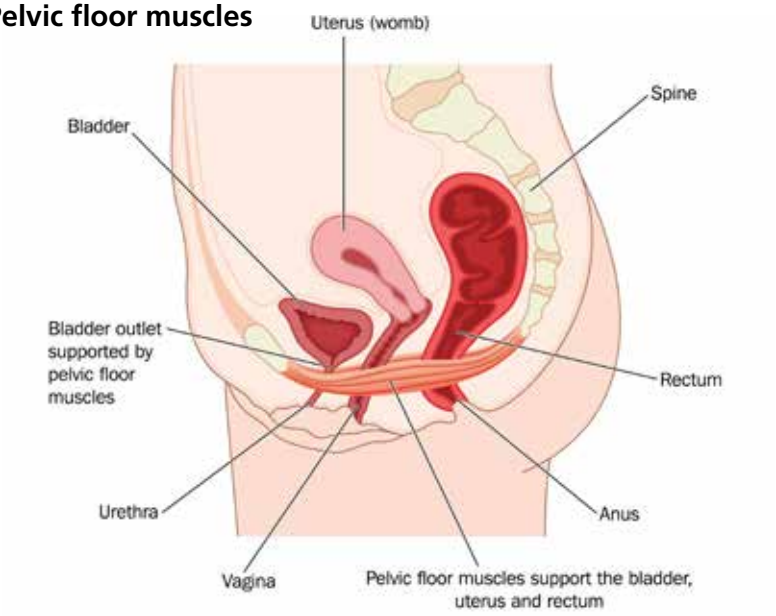


Fig 2. Pelvic floor muscles



The functions of your pelvic floor muscles are to:

- Support the contents of your pelvis.
- Help you control 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 and thins out, helping the baby to turn its head into the correct position, ready for birth.

What is meant by perineal trauma?

During your birth you may have some degree of perineal trauma. Perineal trauma is any damage to the genitalia during childbirth that occurs spontaneously (tears) or by a surgical cut (episiotomy). Frontal perineal trauma includes tearing to the labia, anterior vaginal wall, urethra or clitoris. Posterior perineal tearing involves the back of the vaginal wall, perineal muscles or anal sphincter (muscle which controls your bowels opening and closing). Perineal trauma occurs during spontaneous or instrumental vaginal delivery. It 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

The types of trauma have been classified as:

- **First degree** – tearing to the perineal skin only which usually heals naturally.
- **Second degree (equivalent to a cut)** – tearing to the perineal muscles and skin, these will need stitches.

- **Third degree** – tearing to the anal sphincter muscles (which control the anus), which may or may not involve the perineal muscles.
- **A fourth degree tear** – deeper than a third degree tear and extends to the anus or rectum. It includes the internal and external anal sphincters (Adapted from NICE Intrapartum Care 2017 and RCOG 2015).

What are the risk factors linked to perineal trauma?

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

- Having your first baby because the perineal tissues have not stretched before.
- South Asian origin (Monteiro et al 2016).
- Having a big baby – weight over 4,000 gms (8.8 lbs).
- A quick labour and birth, as there is not enough time for your perineal muscles to stretch and thin out.
- A second stage of labour longer than 4 hours, because your perineal muscles become tired.
- The position of baby at birth – 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 out from an episiotomy (cut).
- 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 and need for an episiotomy (Sultan & Thakar et al 2007) or your baby has their hand over their head.

Frequently asked questions

What is my likelihood of tearing?

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?

Approximately six percent 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 endo-anal ultrasound scan will confirm this. It also depends on 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 incontinency 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 necessary this time?

The decision for a vaginal birth or caesarean section will depend on a number of factors. These can to be discussed with the Consultant in the Birth Options Clinic (BOC) and Specialist Perineal Care Midwife. You will be given information and advice about both types of birth for you to make a fully informed choice. If you are having symptoms of any type of incontinency, or an endo-anal ultra-sound 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 happening. 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?

An episiotomy is a cut into the perineal muscles made by the midwife or doctor to increase the vaginal opening and to make more space for your baby's birth. An episiotomy is only made with your consent and if clinically indicated. Episiotomy is not a routine procedure in the UK. About 22% of women will need one (National Maternity and Perinatal Audit 2018). It is mainly done if the baby gets into difficulty and we need to deliver him/her quickly. It is usually done for an instrumental delivery, if there is a risk of a third or fourth-degree tear or you have a history of female genital mutilation (FGM).

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

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

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

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?

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 considered before making a decision with you for your mode of delivery. With good perineal preparation, you can reduce your risk of having a perineal tear.

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 a perineal tear. It has shown to reduce the number 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 your previous birth. You can discuss your request with the Consultant and Home Birth Team. Contact Tanya Ashton at tanya.ashton@nhs.net

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 perineal care and birth plan. FGM does not mean that you will have to have a CS. Depending on the type of your FGM it is possible for you to have your FGM reversed during your pregnancy or labour so that you can have a vaginal birth. 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 and birth plan. This plan 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 (Tel: 01483 406717), GP or you can self-refer to Angie Wilson at a.wilson12@nhs.net

How can I prepare my perineum during pregnancy?

There are a number things that you can do to reduce perineal tearing, 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 has shown to reduce the incidence of severe tears (Wilson 2014).

Eat a healthy diet with adequate fluid intake

A balanced diet with polyunsaturated fats (good fats) plus green and yellow vegetables aids good health, improves perineal blood circulation (blood flow), and perineal skin elasticity. Vitamin C, found in fresh oranges and red fruits has also shown to increase collagen production, adding strength and regeneration (new growth) to your perineal muscles before and after birth. Foods high in fibre, drinking plenty of fluids – approximately 1.5 litres per day, minimizes constipation (hard poo) 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. A healthy body mass index (BMI) 25–29.9 kg/m² 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)

It is important to practice PFEs to strengthen your 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 the 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 (slipping forward) 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 to hurry to use the toilet. A weakened anal sphincter muscle may lead to a lack of control passing wind or faeces (poo). 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 greatly reduce stress urinary incontinence during the third part of the pregnancy and during the postnatal period. They may also protect you against anal incontinence and are particularly beneficial for women who have had a large baby or experienced a previous forceps delivery. (Boyle & Hay-Smith et al 2012, Woodley et al 2017). 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 numbers of women with perineal trauma needing stitches (Ellington et al 2017)
- the numbers of episiotomy in women having their first baby and women who have not previously given birth vaginally
- reducing postnatal perineal pain in women having more than one baby (Beckmann & Stock 2013)
- women over 32 years of age because the collagen, which strengthens perineal tissues, is reduced 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 (tough) perineum – sometimes seen in women who ride or dance regularly.

When can I start perineal massage?

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

Instructions for perineal massage

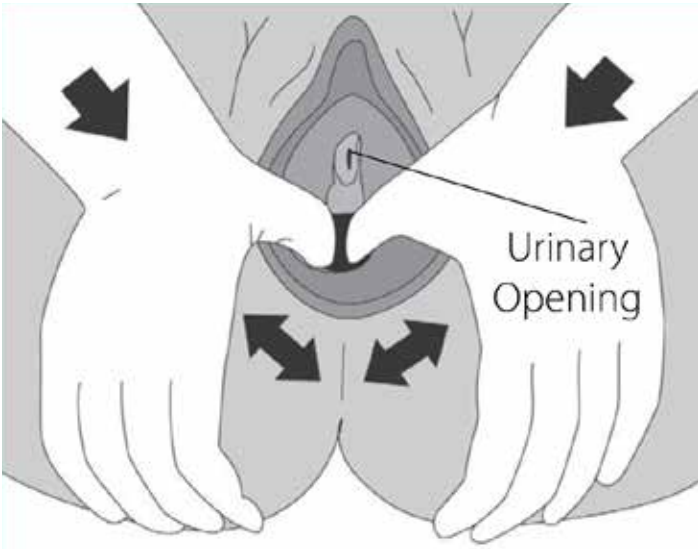
- You or your partner can undertake perineal massage.
- Wash your hands well and keep your fingernails short.
- Relax in a private place, sitting with your knees bent in an upright position. Some women like to lean on pillows for back support.
- It helps to have a bath, shower or warm pad on the perineum first to encourage a good blood supply to the perineal tissues.
- Lubricate (oil) 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 Fig. 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 (likening to) the baby's head birthing.
- With your thumbs, slowly massage the lower half of the vagina using a 'U' shaped movement (3-9 0'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 take away this protective effect (Beckmann & Stock 2013). 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.
- Perineal massage should NOT be painful.
- Your partner can also massage your perineum using the same method. They should use their index finger (first 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) Ellington et al 2017

Massage **should not** be performed 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.

Fig 3. Perineal Massage



Can I use perineal stretching devices

Perineal stretching devices have not been included in this booklet as they are still being studied for positive effects. (Kavvadias & Hoesli 2016)

Minimising perineal trauma during labour and birth

What are the best positions for labour and birth to reduce trauma?

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 a lateral position (lying on your side) in contrast to a semi-recumbent or lithotomy position (semi-sitting/lying) for birth has been shown to reduce the need for an episiotomy and reduces the risk of third degree perineal tears particularly if this is your first baby (Baker 2010, RCM 2010, Meyvis & Rompaey et al 2012, Edqvist et al 2016). 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 2017).

Application of a warm compress (pad) to the perineum during the second stage of labour

Your midwife or birth partner can be encouraged to apply a warm compress to your perineum during the last part of the second stage of labour, helping the baby's head 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. Warm compresses have shown to greatly reduce third and fourth degree tears and pain at birth (Dahlen 2007, RCOG 2015, & Aasheim et al 2017).

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 guidance with pushing particularly if they have an epidural for pain relief. You will be asked to slow the birth of the baby's head at the point of crowning and breathe the head out between your contractions. Going with your natural urges has been shown to increase the likelihood of an intact perineum, reduce the need for an episiotomy, and reduce the risk of second, third degree or fourth degree tears (Laine & Skjeldestad et al 2012, RCOG 2017).

'Hands on' or 'hands poised' 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). They will observe your perineum and support it to minimise tearing, referred to as manual perineal protection (MPP). A controlled birth has been shown to reduce severe (third and fourth degree tears) perineal trauma up to 50% (Laine & Skjeldestad et al 2012, RCOG 2015, Naidu et al 2017). Some midwives are now using the acronym PEACHES (Position at birth – Extra pair of hands – Assess the perineum throughout labour – Communication – 'Hands on' technique – Episiotomy (if required) – Slowly birth the baby. This practice has shown to reduce third and fourth degree tears (Novis 2016).

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 (lengthening) into a further tear or into the anal sphincter muscle is greatly reduced due to a wider angle (direction) of incision (60 degrees) being performed when needed (Freeman & Hollands et al 2014, RCOG 2015).

Water for labour and birth

Birthing in water has not been shown to lead to an increased number of perineal tears (Dekker 2018). However, there is no research to date comparing outcomes of women with previous third /fourth degree tears birthing on land and in water. 'Hands off' management in water when you birth your baby may be associated with an increased number of third degree tears due to the expulsive nature of the head and shoulders at birth. If you have a history of a third or fourth degree tear, it may be better to relax in water and get out for the birth to avoid further trauma (Cortes & Basra et al 2011: 27). However, the choice is yours. The midwives and doctors at the RSCH follow hospital policy to make sure your birth is safe.

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 help you to have a more comfortable and positive birth experience. When relaxation replaces the fear of childbirth, your endorphins (natures 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 refer to: http://royalsurrey.nhs.uk/maternity

Assessment of your perineum following the birth

The National Institute for Health and Care Excellence – Intrapartum care (NICE 2017, RCOG 2015) recommend that all women having a vaginal delivery should have a thorough assessment of the genitalia and vagina. A rectal examination will also be performed 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 (permission) will be sought to perform this procedure. (Andrews et al 2006, Sultan & Thakar 2007, RCOG 2015)

Repair of tears and episiotomy

Leaving first and second degree tears or an episiotomy un-sutured is linked to poorer wound healing and some short-term perineal discomfort (NICE 2017, RCOG 2015). An episiotomy usually extends into the deeper muscle layer and will require suturing. Continuous stitches are inserted into the vagina, perineal muscles and under the skin layer. This method reduces short-term pain (Kettle & Johanson 2004). Occasionally, individual stiches are inserted if the tear is more complex (complicated). 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 (restore) perineal muscle function for future childbirth, maintain good continence and sexual intercourse. Third and fourth degree tears are repaired in theatre under regional (epidural or spinal) or a 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 suggested 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 usually be undertaken to make more space to deliver your baby. It is slightly less common with a ventouse. 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. Recovery time depends on the extent of your trauma. 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 good pain relief can be prescribed. The midwife will assess your perineum alongside individualised postnatal care (Webb et al 2014, NICE 2015).

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 perform your postnatal check. It is beneficial for you that the midwife looks at your perineum to assess for healing and any signs or symptoms of infection or offensive lochia (blood loss). This assessment should be performed either by lying on your side or semi-recumbent (semi-sitting). This will ensure that the midwife can see your perineum clearly to perform a thorough assessment.

How you can minimise perineal infection

To minimise the risk of infection and wound breakdown, personal hygiene is very important. Undertaking a daily bath or shower and performing a good hand-washing technique before and after visiting the toilet and 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 or low temperature over 38°C or less than 36°C (feeling hot or cold) and 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 and 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 – Think infection, think sepsis (MBRRACE-UK 2017).

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 (pee) 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 helps 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 (due to a low haemoglobin level) may slow wound healing. If you have a wound that has broken down to a large degree and healing is not taking place then you may need to be admitted to hospital for re-suturing. Contact your midwife or GP.

How to protect your perineal stitches when having your bowels open

Most women feel anxious about having their bowels open (having a poo) 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 an old pair of knickers 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 2010). 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. 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 are 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 homoeopath 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?

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 your baby and that any perineal discomfort is treated 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

Managing third or fourth degree tears after birth

If you have 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 perineal wound infection. Laxatives such as lactulose and a bulking agent such as fybogel 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 manometry (to measure anal strength) and endo-anal ultrasound scan investigation to assess the function and anatomy of your anal sphincter muscles.

Postnatal Pelvic Floor Exercises or PFMT

Continuing with PFEs after birth is important due to over stretching and weakening of your perineal muscles 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 (Boyle 2012). Please refer to the leaflet: Postnatal Advice and Exercises Following Childbirth from the physiotherapist.

When can I commence sexual intercourse again?

Resuming sexual intercourse is dependent on the degree of your perineal trauma, your blood loss, healing, and how you feel both physically and mentally. Healing can take between three to six 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 a

lack of oestrogen. This is particularly true if you are 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 (Rogers et al 2009).

What if you have perineal problems following your 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 (help)

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

Bladder and Bowel Foundation

www.bladderandbowelfoundation.org

Masic Foundation (Mothers and Anal Sphincter Injuries in Childbirth

www.masic.org.uk

Incontinence Foundation

http://www.continence-foundation.org.uk/

Female Genital Mutilation

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

Notes

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PALS and Advocacy contact details

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.

Past review date: October 2018
Future review date: October 2021
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PIN181024–1590