

Perineal Care

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Note:

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:

The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.



Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

This guideline provides clinicians with information for perineal care during pregnancy, birth and postnatally. It includes actions that have a protective effect against perineal trauma and methods for reducing pain and discomfort and improving perineal function in the postnatal period.



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Summary of Practice Recommendations

- > Offer all women information and antenatal education on measures that may have a protective effect against perineal morbidity including antenatal perineal massage and regular pelvic floor muscle training
- > The use of either hands on or hands off (poised) at the time of birth should reflect the clinician's skill, clinical situation and informed choice of the woman.
- > Warm compresses with 'crowning' reduce third and fourth degree tears
- > A slow steady progressive descent of the presenting part will help minimise perineal trauma
- > In cases where rapid descent of the presenting part occurs, encourage maternal control and minimise active pushing
- > Use of episiotomy should be limited to cases of fetal compromise with selective use in operative vaginal delivery
- > Right medio-lateral technique for episiotomy should be used if required
- > Postnatal information should be given to the woman, including the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises
- > Apply cold packs for 10 to 20 minutes at intervals in the first 24 to 72 hours following birth
- > Offer analgesia and urinary alkalisers to minimise perineal pain
- > Visually assess the repair and healing process at each postpartum check and inform the woman

Abbreviations

BMI	Body mass index
cm	Centimetre
e.g.	For example
L	Litre(s)
mg	Milligram(s)
NSAIDs	Nonsteroidal anti-inflammatory drugs
OASIS	Obstetric anal sphincter injury
PFMT	Pelvic floor muscle training
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Introduction

- > Perineal injury related to childbirth is a common occurrence and the majority of women experience early postpartum perineal pain or discomfort¹
- > Perineal injury includes injury to the labia, vagina, urethra, clitoris, perineal muscles or anal sphincter. This may occur spontaneously during a vaginal birth, or from the trauma of an operative delivery or by an episiotomy²
- > Longer term morbidity may include dyspareunia and anal sphincter injury¹. For further information see *Third and Fourth Degree Tear Management* PPG at www.sahealth.sa.gov.au/perinatal
- > In South Australia in 2010³, of women who gave birth vaginally:
 - > 3,552 (26.6%) had an intact perineum
 - > 2,482 (12.6%) had an episiotomy
 - > 5,725 (42.9%) had a repair of a perineal tear
 - > Of whom 450 (3.4%) had sustained a third or fourth degree tear (18.5% of these women had an episiotomy)³

Antenatal care

- > Offer all women information and antenatal education on measures that may have a protective effect against perineal morbidity. This includes measures that protect against:
 - > Perineal injury
 - > Perineal pain
 - > Pelvic floor dysfunction⁴
- > Undertake perineal assessment early in the antenatal period (e.g. by detailed history taking, visual inspection) and consult with an obstetrician if a history of anal sphincter injury or genital mutilation is identified (see *Female Genital Mutilation* PPG at www.sahealth.sa.gov.au/perinatal)

Raspberry leaf tea

- > There is insufficient evidence to recommend a safe standard for use of raspberry leaf tea or extract (believed to strengthen, tone and relax the pelvic muscles)⁴

Perineal techniques to reduce intrapartum perineal trauma

Perineal massage⁵

- > Women should be informed about the benefits of digital antenatal perineal massage
 - > Perineal massage during the last month of pregnancy (once or twice a week from 35 weeks) may help the perineal tissue expand more easily during birth
 - > In primigravidae, perineal massage may reduce the likelihood of perineal trauma (mainly episiotomies) and ongoing perineal pain

Pelvic floor muscle training⁶

- > Women should be informed about the benefits of doing regular pelvic floor muscle training (PFMT)
- > Follow recommendations in the Continence Foundation of Australia "[pelvic floor muscle training for women](#)" leaflet
 - > In primigravidae, pelvic floor muscle exercises can prevent urinary incontinence up to six months after delivery
 - > It is possible that the effects of PFMT might be greater in certain groups of women (e.g. primigravidae; bladder neck hypermobility in early pregnancy, a large baby, or a forceps delivery). Further testing is advised, particularly for long-term effectiveness⁶
- > Consider referring women with a past history of pelvic floor dysfunction (e.g. previous 3rd degree tear, pelvic floor or incontinence surgery) to a women's health physiotherapist for a pelvic floor exercise refresher

Perineal stretching devices⁷

- > Small studies of the EPI-NO have shown a beneficial effect on reducing perineal damage during vaginal birth, especially with nulliparous women
- > There does not appear to be an increase in pelvic floor damage or infection associated with antenatal use of the device
- > Antenatal perineal massage is an effective alternative to the EPI-NO device⁷



Intrapartum care

Maternal position⁸

- > Evidence does not support specific positions for the protection of the perineum during active pushing
- > Encourage the woman to adopt the position in which she is most comfortable (usually upright)

Pushing techniques

- > Evidence does not support any specific pushing techniques (e.g. delayed pushing versus immediate pushing, bearing down versus spontaneous pushing) for the protection of the perineum⁴
- > Pushing and bearing down methods and fetal and maternal outcomes (e.g. on pelvic floor structures and bladder function) are the subject of a Cochrane protocol that will aim to compare directed pushing during the second stage with supporting the woman's instinctive responses⁹

Warm compresses and perineal massage¹⁰

- > Associated with a reduction in the incidence of 3rd and 4th degree tears¹⁰

Hands on versus hands off

- > Hands off (poised) versus hands on showed no effect on third- and fourth-degree tears; however hands off (poised) is associated with a reduced rate of episiotomy¹⁰
- > The use of either hands on or hands off (poised) should reflect the clinicians skill, clinical situation and informed choice of the woman. A slow steady progressive descent of the presenting part will help maximise the stretch and minimise trauma¹¹(suitable in term labour where fetal wellbeing is not compromised)
- > Additionally, the use of hands on, hands poised, +/- warm compresses will depend on the following:
 - > The woman's adopted position
 - > fetal wellbeing
 - > speed of descent of the presenting part
- > In cases where rapid descent of the presenting part occurs, encourage maternal control, whilst maximising flexion to the fetal head to help reduce the presenting diameter with the aim of minimising rapid passage of the larger diameters of the fetal head through the vaginal opening
- > Once the fetal head is crowned, with the woman's control:
 - > Minimise active pushing (encourage the woman to breathe or pant rather than push) to ensure a slower descent of the head¹¹
 - > Consider if there is any benefit of counter pressure to the fetal head to prevent rapid expulsion

Fetal position and size

- > The size of baby and optimal fetal position may also have an impact on perineal trauma
- > Further studies reviewing maternal body mass index (BMI) and fetal occipital posterior positions when considering perineal outcomes are required¹¹



Interventions

Epidural¹²

- > Women who have an epidural in labour have an increased risk of instrumental delivery and associated perineal morbidities (e.g. episiotomy, anal sphincter injury)

Episiotomy

- > RANZCOG recommend restrictive use of (right) medio-lateral episiotomy (e.g. fetal compromise, selective use in operative vaginal delivery)¹³
- > Episiotomy is associated with more anterior vaginal traumas (minimal long term morbidity)^{14,15}
- > Verbal informed consent should be obtained
- > The mediolateral episiotomy is preferred over medial episiotomy as it is associated with lower rates of obstetric anal sphincter (OASIS) injury¹⁵
 - > Anatomical structures involved include vaginal epithelium, transverse perineal and bulbocavernosus muscles; and perineal skin¹⁵
 - > **Technique:** An incision is made under appropriate analgesia (e.g. 1% lignocaine), 3-5 cm in length from the fourchette at an angle **60-80** degrees to the midline at the time of distension of the perineum by the presenting part. After delivery, the angle becomes 45 degrees from midline¹⁵

Postpartum perineal care⁴

Immediate postpartum

- > Information should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises
- > Rectal non-steroidal anti-inflammatory drugs (NSAID) e.g. diclofenac 100 mg, should be offered routinely immediately following perineal repair of first- and second-degree trauma provided these drugs are not contraindicated (see *Perineal Repair* PPG available at www.sahealth.sa.gov.au/perinatal)
 - > **Contraindications** include postpartum haemorrhage, hypersensitivity to NSAIDs, concurrent use of other NSAIDs, aspirin, digoxin
- > Offer oral / rectal paracetamol one gram after perineal repair
- > If tears are within close proximity of the urethra, consider an indwelling catheter for the first 24 hours

Early postpartum⁴

Reduce pain and swelling:

- > Advise the woman to apply cold packs for 10 to 20 minute intervals for 24 to 72 hours
- Offer:
- > Oral paracetamol one gram every 6 hours as required
 - > Oral NSAID in the absence of contraindications (see above)
 - > Urinary alkalisers to reduce urine acidity and discomfort associated with grazes, unsutured tears
- > Where possible, minimise the use of codeine and other narcotics to reduce the risk of constipation

Diet⁴

- > Encourage a healthy balanced diet with high fibre food choices
- > Advise to drink 1.5 to 2 L water per day (particularly if ordered laxatives or oral iron supplementation)



Healing / hygiene⁴

- > Visually assess the repair and healing process at each postpartum check and share the findings with the woman
- > Advise the woman to:
 - > Support the perineal wound when coughing or defecating
 - > Avoid constipation
 - > Use the correct sitting position on the toilet, elbows on knees, leaning forward with feet supported on a foot-stool to aid defecation
 - > Wash and pat dry perineal area after toileting
 - > Change perineal pads frequently, wash hands before and after changing and shower at least daily to keep the perineum clean
 - > Check the wound daily with a hand mirror – provide education about the signs of infection and wound breakdown
 - > Report any concerns to the midwife or General Practitioner

Pelvic floor muscle exercises

- > Advise the woman to commence when comfortable see instructions in Continence Foundation Australia “Pelvic floor muscle training for women” information leaflet

Positioning and movement⁴

- > Advise positions that reduce dependent perineal oedema, particularly in the first 48 hours, such as:
 - > Lying the bed flat and side-lying to rest and breastfeed, try pillow-supported ‘recovery’ position, avoid overuse of sitting/propped positions
- > Avoid activities that increase intra-abdominal pressure for 6-12 weeks post birth such as:
 - > Straining, lifting, high impact exercise, sit ups - move in and out of bed through a side lying position

Uncorroborated clinical measures⁴

Evidence is lacking to support the following measures:

- > Perineal ultrasound to treat perineal pain or dyspareunia
- > Topical anaesthetics for perineal pain
- > Sitz baths
- > Ray lamps
- > Perineal donut cushions (may lead to formation of dependent perineal oedema and increased risk of perineal wound breakdown)
- > Herbal remedies (e.g. arnica) topical or ingested

Follow-up⁴

- > For women with anal sphincter injury, for follow-up advice see *Third and Fourth Degree Tear Management* PPG at www.sahealth.sa.gov.au/perinatal

Perineal injury⁴

- > Self-care advice until review with general practitioner around 6 weeks postpartum for assessment of wound healing
- > Advise the woman to seek medical review earlier if any signs of wound infection or breakdown



Dyspareunia⁴

- > Women with perineal suturing are at increased risk
- > Wound healing is one of many factors that influences the decision to resume sexual intercourse
- > Delayed reporting is common due to median time of return to intercourse being 5-8 weeks postpartum
- > Explain ways to minimise discomfort (e.g. experimenting with sexual positions, use of lubrication)
- > Advise the woman to seek medical review if ongoing constipation or symptoms of urinary or faecal incontinence



References

1. Kettle C, Fenner DE. Repair of episiotomy, first and second degree tears. In: Sultan AH, Thakar R, Fenner DE, editors. Perineal and anal sphincter trauma. London: Springer-Verlag; 2009. p. 20-31.
2. Joanna Briggs Institute (JBI). Perineal and genital trauma. Best practice 2010.
3. Scheil W, Scott J, Catcheside B & Sage L. Pregnancy Outcome in South Australia 2010. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2012.
4. Queensland Maternity and Neonatal Clinical Guideline. Perineal care. Queensland Health; 2012. Available from URL: http://www.health.qld.gov.au/qcg/documents/g_pericare.pdf
5. Beckmann MM, Stock OM. Antenatal perineal massage for reducing perineal trauma. Cochrane Database of Systematic Reviews 2013, Issue 4. Art. No.: CD005123. DOI: 10.1002/14651858.CD005123.pub3. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005123.pub3/pdf/standard>
6. Boyle R, Hay-Smith EJC, Cody JD, Mørkved S. Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD007471. DOI: 10.1002/14651858.CD007471.pub2. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007471.pub2/pdf/standard>
7. Daniels B. The final stretch. In: Royal Australian and New Zealand College of Obstetrics and Gynaecology. Obstetrics and Gynaecology magazine 2014; 161:24-25.
8. Gupta JK, Hofmeyr GJ, Shehmar M. Position in the second stage of labour for women without epidural anaesthesia. Cochrane Database of Systematic Reviews 2012, Issue 5. Art. No.: CD002006. DOI: 10.1002/14651858.CD002006.pub3. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002006.pub3/pdf/standard>
9. Lemos A, Amorim MMR, Dornelas de Andrade A, de Souza AI, Cabral Filho JE, Correia JB. Pushing/bearing down methods for the second stage of labour. Cochrane Database of Systematic Reviews 2011, Issue 5. Art. No.: CD009124. DOI: 10.1002/14651858.CD009124. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009124/pdf>
10. Aasheim V, Nilsen ABV, Lukasse M, Reinart LM. Perineal techniques during the second stage of labour for reducing perineal trauma. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD006672. DOI: 10.1002/14651858.CD006672.pub2. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006672.pub2/pdf/standard>
11. Dixon L. The unkindest cut? In: Royal Australian and New Zealand College of Obstetrics and Gynaecology. Obstetrics and Gynaecology magazine 2014; 161:26-27.
12. Anim-Somuah M, Smyth RMD, Jones L. Epidural versus non-epidural or no analgesia in labour. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD000331. DOI: 10.1002/14651858.CD000331.pub3. Available from URL: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000331.pub3/pdf/standard>
13. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Routine intrapartum care in the absence of pregnancy complications. C-Obs 31. March 2011. Available from URL: <http://www.ranzcog.edu.au/college-statements-guidelines.html>
14. White L. Explaining episiotomy. In: Royal Australian and New Zealand College of Obstetrics and Gynaecology. Obstetrics and Gynaecology magazine 2014; 28-29.

Useful references

Continence Foundation of Australia: Pelvic floor muscle exercises. Available from URL: <https://www.continence.org.au/resources.php/01tA0000001b1e4IAA/06-pelvic-floor-muscle-training-for-women>



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