POCKET BOOK OF

# PERIANAL CARE FOR THE PAEDIATRIC ONCOLOGY PATIENT

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WIJAYA HUSADA HEALTH SCIENCE INSTITUTE

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# Perianal Care For The Paediatric Oncology Patient

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# PREFACE

Thank to Almighty God who has given His bless to the writer for finishing the "*Pocket Book Of Perineal Care For The Paediatric Oncology Patient".* The *Pocket book* is part of a series of tools for improving the quality of care for severely ill children and is consistent with the Integrated Management of Childhood Illness guidelines for outpatient management of sick children. It is for use by doctors, senior nurses and other senior health workers who are responsible for the care of young children at the fi rst referral level in developing countries.

The *Pocket book* is presented in a format that could be carried by nurses and other health workers during their daily work and be available to help guide the Perianal Care For The Paediatric Oncology Patient. Although some new topics have been added, standard textbooks of paediatrics should be consulted for rarer conditions not covered in the *Pocket book*. These guidelines are applicable in most areas of the world and may be adapted by countries to suit their specific circumstances.

Bogor, 2019

# Contents

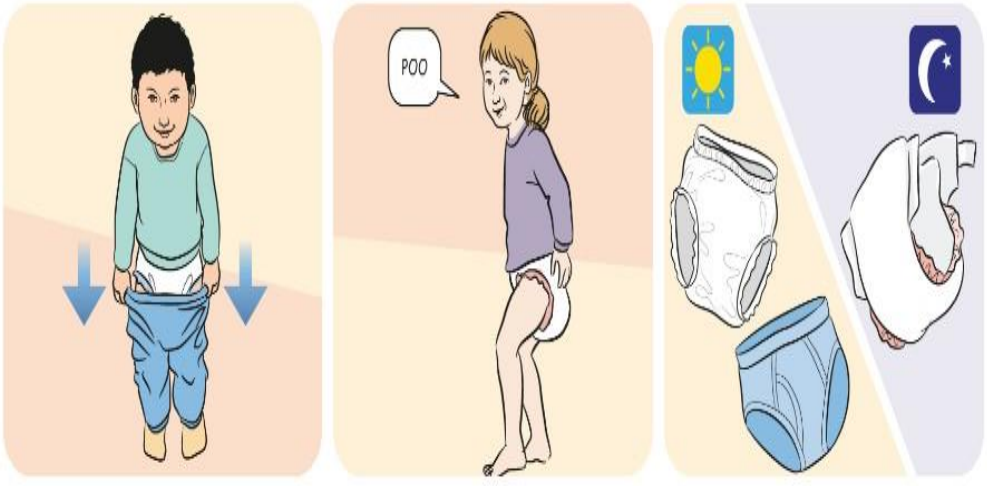
# TOILET TRAINING

## Signs that your child is ready

You might see signs that your child is ready for toilet training from about two years on. Some children show signs of being ready as early as 18 months, and some might be older than two years.
Your child is showing signs of being ready if they:

- are walking and can sit for short periods of time
- are becoming generally more independent when it comes to completing tasks, including saying „no" more often
- are becoming interested in watching others go to the toilet – this can make you uncomfortable, but it"s a good way to introduce things
- have dry nappies for up to two hours – this shows they can store wee in their bladder (which automatically empties in younger babies or newborns)
- tell you with words or gestures when they do a poo or wee in their nappy – if they can tell you before it happens, they"re ready for toilet training
- begin to dislike wearing a nappy, perhaps trying to pull it off when it"s wet or soiled
- have regular, soft, formed bowel movements
- can pull their pants up and down
- can follow simple instructions like „Give the ball to daddy"
- show understanding about things having their place around the home.

Not all these signs need to be present when your child is ready. A general trend will let you know it"s time to start.




- If your child has dry nappies for up to two hours and knows he"s doing a wee or a poo, he could be ready for toilet training. It"s handy if he can pull his pants up and down.
- Your child might also be ready if he"s interested in the toilet and wants to watch you use it. He might tell you if there"s a wee or a poo in his nappy.
- Your child can use underpants or training pants during the day. He can use a nappy when you can"t get to a toilet easily, or during daytime and night-time sleeps.

If you"re thinking about toilet training, you might like to check out our toilet training guide in pictures. You could even print it out and stick it up somewhere handy.

# Getting ready for toilet training

If you think your child is showing signs of being ready for toilet training, the first step is to decide whether you want to train using a potty or the toilet. There are some advantages to using a potty – it"s mobile and it"s familiar, and some children find it less scary than a toilet. Try to find out your child"s preference and go with that. Some parents encourage their child to use both the toilet and potty. Second, make sure you have all the right equipment. For example, if your child is using the toilet you"ll need a step for your child to stand on. You"ll also need a smaller seat that fits securely inside the existing toilet seat, because some children get uneasy about falling in.

Third, it"s best to plan toilet training for a time when you don"t have any big changes coming up in your family life. Changes might include going on holiday, starting day care, having a new baby or moving house. It can be a good idea to plan toilet training for well before or after these changes.

Also, toilet training might go better if you and your child have a regular daily routine. This way, the new activity of using the toilet or potty can be slotted into your normal routine.

Here are some tips for getting ready:

- Teach your child some words for going to the toilet – for example, „wee", „poo" and „I need to go".
- When you change your child"s nappy, put wet and dirty nappies in the potty – this can help your child understand what the potty is for.
- Let your child try sitting on the potty or the small toilet seat to get familiar with the new equipment.
- Let your child watch you or other trusted family members using the toilet, and talk about what you"re doing.
- Once or twice a day you might want to start putting trainer pants on your child. This helps your child understand the feeling of wetness.

- Make sure your child is eating plenty of fibre and drinking lots of water so your child doesn"t get constipated. Constipation can make toilet training harder.

Once you start, toilet training might take days, weeks or months. The key is to not push your child, and let your child learn at their own pace. Your child will get the hang of it in time. And if your child doesn"t cooperate or seem interested in toilet training right now, just wait until they want to try again.

## Starting toilet training

It"s a good idea to start toilet training on a day when you have no plans to leave the house. The tips below can help with toilet training once the big day arrives.

**Timing**

- Sit your child on the potty at times when poos often happen, like 30 minutes after eating or after having a bath. This doesn"t work for all children – true toilet training begins when your child is aware of doing a wee or poo and is interested in learning the process.
- Look out for signs that your child needs to go to the toilet. Cues include changes in posture, passing wind, going quiet or moving to a different room by themselves.
- If your child doesn"t do a wee or poo after 3-5 minutes of sitting on the potty or toilet, take your child off. It"s best not to make your child sit on the toilet for long periods of time, because this will feel like punishment.

**Encouraging and reminding your child**

- Praise your child for trying (even if progress is slow), especially when they"re successful. You could say, „Well done for sitting on the potty". This lets your child know they"re doing a good job. Gradually reduce the amount of praise as your child masters each part of the process.

- At different stages throughout the day (but not too often), ask your child if they need to go to the toilet. Gentle reminders are enough – it"s best if your child doesn"t feel pressured.
- If your child misses the toilet, try not to get frustrated. Children don"t usually have accidents on purpose, so just clean up without any comments or fuss.

**Pants and clothing**

- Stop using nappies (except at night and during daytime sleeps). Start using underpants or training pants all the time. You can even let your child choose some underpants, which can be an exciting step.
- Dress your child in clothes that are easy to take off – for example, trousers with elastic waistbands, rather than full body suits. In warmer weather, you might like to leave your child in underpants when you"re at home.

**Hygiene**

- Wipe your child"s bottom until your child learns how. Remember to wipe from the front to the back, particularly with girls.
- Teach your son to shake his penis after a wee to get rid of any drops. Early in toilet training it sometimes helps to float a ping pong ball in the toilet for your son to aim at. Or he might prefer to sit to do a wee, which can be less messy.
- Teach your child how to wash hands after using the toilet. This can be a fun activity that your child enjoys as part of the routine.

# Toilet Training Basic


- Dress your child in clothes that are easy to take off, like pants with elastic waistbands.
- Watch for signs that your child might need to use the toilet. She might jiggle or hold her hand between her legs. Gently remind her to sit on the toilet during the day.
- Sit your child on the toilet when a poo is likely – for example, about 30 minutes after a meal. About 3-5 minutes is long enough for your child to sit.

Often, children are 3-4 years old before they"re dry at night. One in 5 five-year-olds and 1 in 10 six-year-olds still uses nappies overnight. And bedwetting is very common in school-age children. If your child wets the bed, there are things you can do about it when you and your child are ready.

# Good Toileting Habits


- Have your child sit comfortably on the toilet. Sitting with his feet and legs apart and leaning forward with a straight back will help him empty out wee and poo. He can use a footstool to support his feet.
- Wipe your child"s bottom or help with wiping. Ask him to bend forward. Always wipe from front to back. If your child misses the toilet and wee or poo gets on the floor, just clean it up without fuss or comment.
- Help your child wash his hands, then give him lots of praise for doing a wee or poo in the toilet. If you"re ever concerned about your child"s toileting, speak to your health professional.

## Training Pants and pull-ups

Your child is more likely to understand toilet use if they're no longer wearing a nappy. Training pants are absorbent underwear worn during toilet training. They're less absorbent than nappies but are useful for holding in bigger messes like accidental poos. Once your child is wearing training pants, dress your child in clothes that are easy to take off quickly. Pull-ups are very popular and are marketed as helpful for toilet training. It isn't clear that they actually help. But you can try them to help your child get used to wearing underwear. Generally, cloth training pants are less absorbent than pull-ups and can feel a little less like a nappy. Pull-ups might be handier when you're going out. Wearing training pants is a big move for your child. If you celebrate it, the transition will be easier. Talk about how grown-up your child is and how proud you are.

## Out and about while toilet training

It's easier to stay home for a few days when you start toilet training, but you'll probably have to go out at some stage. Wherever you're going, it's a good idea to check where the nearest toilet is. If you're going to a local shopping centre, ask your child if they need to go when you get there. This can help get your child familiar with the new area. It's best to take a spare change of underpants and clothes for your child when you're out, until your child is very confident about using the toilet. It's also a good idea to carry plastic bags for wet or soiled clothes. If your child goes to a child care service or to friends' or relatives' houses without you, let people know that your child is toilet training. This way they can help your child use the toilet or potty in the way that you do at home.

# Setbacks and accidents while toilet training

Learning to do wees and poos in the toilet takes time. You can expect accidents and setbacks – these are all just part of the process.

If your child gets upset because of an accident, reassure your child that it doesn"t matter and there"s no need to worry.

Here are ideas to help avoid accidents:

- Pay attention if your child says they need the toilet straight away. They might be right!
- If you"re sure your child hasn"t done a poo or wee in a while, remind your child that they might need to go. Your child might be so caught up in what they"re doing that they don"t realise they need to go until it"s too late.
- Check if your child wants to go to the toilet during a long playtime or before an outing. If they don"t want to go, that"s fine.
- Try to make sure the potty or toilet is always easy to get to and use.
- Ask your child to wee just before going to bed.

Try to stay calm if toilet training seems to take longer than you expect. Stay positive about your child"s achievements, because your child will get there eventually. Too much tension or stress can lead to negative feelings and might result in your child avoiding going to the toilet.

# Health problems

It's worth keeping an eye out for possible problems connected with toilet training. Signs to look for include:

- a big increase or decrease in the number of poos or wees
- poos that are very hard to pass
- unformed or very watery poos
- blood in the poo or wee (sometimes appears as cloudy wee)
- pain when your child goes to the toilet.

If you feel there might be a problem or you're worried about how your child is adapting to toilet training, check with your GP or child and family health nurse.

# PERSONAL HYGIENE

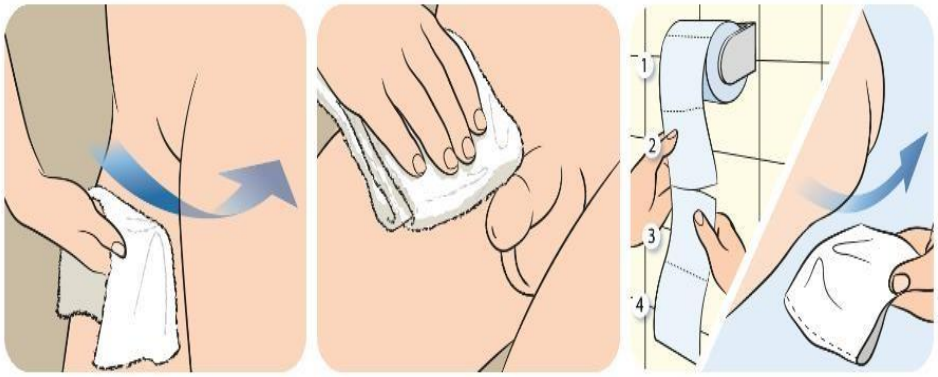
## Personal hygiene: washing, bathing, and drying

- Hand-washing stops the spread of germs. Teach your child to wash hands after sneezing, coughing or blowing noses, before touching food, after toileting, after being in public places, and after being near sick people.
- Regular baths or showers keep your child clean and healthy. Bathing at the end of the day can also be part of a bedtime routine. Make the bath fun with games and toys. Never leave your child alone at bath time.
- After bathing, gently rub your child dry with a towel or flannel. Dry all over your child"s body. Drying before getting dressed can help avoid rashes. In warmer weather, your child can air-dry before dressing.

# Personal hygiene: teeth and nose

- Brush teeth twice a day, once in the morning and once before bed. Speak with your dentist about whether your child needs to floss teeth.
- Your child should blow their nose gently when it's blocked – this makes breathing easier. Put used tissues in the bin. Wash hands after blowing.
- Teach your child to cover their mouth with a tissue, sleeve or elbow when sneezing or coughing. Put used tissues in the bin. Wash hands after sneezing or coughing.

# Personal hygiene: cleaning genitals and toileting




- Wash your daughter"s vulva gently in the bath or shower. Wash from front to back to reduce the risk of urinary tract infections. The vagina cleans itself – don"t put anything in it.
- Wash your son"s penis and scrotum the way you wash other body parts. Teach your son to regularly clean his penis tip. Avoid cleaning inside the foreskin until it pulls back easily.
- Teach your child to wipe their bottom with toilet paper. You might have to help with wiping to start. Show how much paper to use by counting squares. Girls should always wipe from front to back.

# PERIANAL CARE

## Vulva skin care for children

While your child is young, the skin around the vulva (external female genital area) can be quite thin, and this can lead to it being easily irritated. Occasional itching around the vulval area is common.

Sometimes, irritation to the skin can cause pain (see our fact sheet Vulvovaginitis). The symptoms are usually not serious and get better with simple steps you can do at home.

Thrush is very uncommon before puberty, so if your child has itching or irritation around the vulva, it is not likely to be thrush. Threadworms can also cause itching and redness around the vaginal area (see our fact sheet Worms).

## Care at home

There are many simple ways to reduce your child's symptoms if they have itch or irritation around the vulva. These suggestions will also help prevent symptoms from returning.

## Clothing and laundry

Wear cotton underwear.

Wear loose-fitting pants or skirts, and avoid tights and leggings.

Ensure that laundry detergent is rinsed well from underwear, and do not use fabric softener on undergarments.

## Hygiene

- Do not over-wash the area. Treat the skin of the vulval area very gently.
- Avoid hot baths.
- Do not use soap for washing while symptoms are present. Alternatives include Cetaphil cleanser, Dermaveen, Hamilton wash, QV or sorbolene.
- When the symptoms have improved, washing with plain water may be enough for good genital hygiene.
- Do not use bubble bath or perfumed soaps or creams, and avoid getting shampoo on the vulval area.
- Try vinegar baths to prevent mild infections in the vulval area and to help relieve itchiness. Add half a cup of white vinegar to a shallow bath and soak for 10 to 15 minutes. Your child can have vinegar baths from once a week to twice a day, depending on how uncomfortable the symptoms are.
- Encourage your child to urinate (wee) when they first feel they need to go to the toilet and avoid 'hanging on'.
- Use soft, uncoloured, unscented toilet paper.

## Physical activities

- Avoid activities that put direct pressure on the vulva (e.g. bicycle riding or horse riding).
- Remove sports clothing soon after exercise.
- Place a frozen gel pack wrapped in a towel against the itchy area to relieve symptoms after exercise.
- Have a break from swimming in chlorinated pools and avoid hot tubs.

- Remove wet bathing suits soon after swimming.
- Avoid long periods of sitting – encourage regular breaks of standing or walking.

## Relieving itch

- Encourage your child to not scratch the area.
- Soak a clean, soft cloth (e.g. an unused Chux) in a bowl with cool water and your soap substitute, and apply to the vulval area to help relieve the itch.
- Never use medication on the genital area that has not been prescribed for this area, because the skin is more sensitive than other skin.

## When to see a doctor

- If your child's itch and irritation remain after trying the suggestions above, see your GP. Also see the GP if your child has:
- pain or burning when urinating
- bleeding or discharge from the vaginal area
- fever or abdominal pain.

## Key points to remember

- Vulval skin is very delicate and needs to be treated gently.
- Occasional itching around the vulval area is common.
- Thrush is uncommon before puberty.
- Vinegar baths and a cool compress may help relieve itch.
- Avoid bubble baths or perfumed soaps and creams.

## For more information

- Kids Health Info fact sheet: Vulvovaginitis
- Kids Health Info fact sheet: Vulval skin care for teenagers
- See your GP.

## Common question our doctors are asked

**How can I get my child to stop scratching?**
It's hard to get a child who is feeling itchy to not scratch, but it is important to discourage scratching so they don't irritate the skin further. Try placing a cold, damp, cloth against the itchy area to relieve the itch, or give your child a vinegar bath. See your GP if nothing seems to help.

**How do I know if my child has thrush?**
It is very rare for children to get thrush before they start menstruating, so vaginal or vulval itching is not likely to be thrush. Vulvovaginitis is more likely. If your child has a thick, white discharge from their vagina (with a „cottage cheese" appearance and yeasty smell) then it may be thrush. If there is a discharge, see your GP.

# PERIANAL CARE FOR THE PAEDIATRIC ONCOLOGY PATIENT

## Definition of terms

**Perianal care** involves maintaining the integrity and function of the skin and mucosal surfaces of the perineum and anal region.
The skin and mucosal surfaces constitute the primary host defense against invasion by endogenous and acquired microorganisms. Any factor that bypasses or disrupts this integumentary barrier can mean there is increased susceptibility to infection.
The paediatric oncology patient is extremely vulnerable to alterations in skin and mucosal surfaces due to the adverse effects of chemotherapy, radiotherapy, immunosuppression and alterations in nutritional status.

## Parameters

The aim of this guidelines is to provide recommended perianal care for the Paediatric Oncology Patient. It outlines the prophylactic and reactive management required for optimal skin and mucosal integrity

## Assessment

The perianal region should be assessed daily by a clinician, either the treating doctor or the nurse managing the patients care.
Report discomfort, erythema, burning, itching, swelling, vesicles, etc.

Document all findings, decisions regarding management and proposed plan of care
The goal is to initiate preventative care of the skin and mucosal surfaces when there is an anticipated risk to the perianal area.

# Management

**Recommended perianal care for the Paediatric Oncology Patient**

**No neutropenia**

***Asymptomatic***

- Daily bath/shower using a mild soap
- If the patient has diarrhoea apply one of the following protective barrier creams to areas of intact skin
    - 10% dimethicone cream every 3 to 4 washes (e.g. Silicare or 3M Cavilon Barrier Cream)
    - 3M No Sting Barrier Film daily

***Mild Excoriation***

- Daily bath/shower using a mild soap
- Gently cleanse with water/saline after voiding or each bowel action
- Pat dry or administer oxygen via tubing to thoroughly dry the area (using separate tubing for inhaled oxygen and topical oxygen).
- Expose the area to air whenever possible
- Apply protective barrier cream to areas of **intact skin** as above
- For severe skin loss contact Stomal Therapist

**Neutropenic**

***Asymptomatic***

- Daily bath/shower using a mild soap
- If the patient has diarrhoea apply one of the following protective barrier cream to areas of intact skin
    - 10% dimethicone cream every 3 to 4 washes (e.g. Silicare or 3M Cavilon Barrier Cream)

- 3M No Sting Barrier Film daily

***Mild Excoriation***

- Daily bath/shower using a mild soap
- Gently cleanse with water/saline after voiding or each bowel action and pat dry
- Expose the area to air whenever possible
- Apply a thin layer of mycostatin t.d.s on areas where candida suspected or present
- Apply protective barrier cream to areas of intact skin as above

***Severe Excoriation***

- B.D. bath/shower using a mild soap
- Gently cleanse with water/saline after voiding or each bowel action
- Pat dry or administer oxygen via tubing to thoroughly dry the area (using separate tubing for inhaled oxygen and topical oxygen).
- Expose the area to air whenever possible
- Apply a thin layer of mycostatin **t.d.s** on areas where candida suspected or present
- Apply a thin layer of SSD cream only to areas of skin loss (discontinue when no longer neutropenic)
- Apply a 3 to 5 mm layer of SSD cream **only to areas of skin loss** (discontinue when no longer neutropenic)
- Apply protective barrier cream to areas of **intact skin** as above
- For severe skin loss contact stomal therapist

**Analgesia regimen for pain associated with perianal excoriation**

- Xylocaine gel 2% may be applied to the external anal area prior to toileting for patients who have an anal tear
- Systemic analgesics (paracetamol, codeine or morphine) may be required, and should be administered according to the degree of pain

**Considerations**

- **PR** medications or enemas, **PR** temperatures, rectal examinations or colonoscopies, tampons, pessaries and douches **should not be used** in the oncology patient. Use indwelling catheters only if unavoidable.
- If perianal excoriation occurs, encourage use of disposable super absorbent gel nappies for infants or children to wear lightweight preferably cotton underwear or pyjamas
- Change nappies frequently, and immediately after each bowel action.
- **Avoid constipation.** Chemotherapy agents such as vinca alkaloids (e.g. vincristine, vinblastine) or the use of narcotic analgesics may cause constipation, therefore aperients and stool softeners are often required. Once constipation occurs, it can be very difficult to treat, so prevention with stool softeners must be instituted early to reduce the risk of an anal tear.
- Intensive chemotherapy regimens (e.g. methotrexate, cisplatin and actinomycin-D), infections or diseases such as graft versus host may cause diarrhoea. Collect stool specimens to exclude infectious causes. Do not administer anti-diarrhoeal agents without fellow/consultant approval.

Many chemotherapy agents may contribute to perianal skin problems, producing erythema and desquamation (e.g. high dose thiotepa, cyclophosphamide and carboplatin).

Adolescents who are sexually active should discuss precautions with their consultants

Nonperfumed baby skin wipes may be used to cleanse the perianal area, however discontinue use if irritation occurs.

**Associated Documents**

Nursing Care Plan- 6 East MR 51D

Febrile Neutropenia Path MR96I

Chemotherapy Clinical Path MR96J

RCH Clinical Practice Guidelines: Constipation

# Clinical Guideline for: The Management of Perineal Trauma following Childbirth

**Background**

Approximately 90% of women will experience some degree of perineal trauma following vaginal delivery. Trauma can occur spontaneously during vaginal birth or by an episiotomy – though it is possible to have both (for example an episiotomy may extend into a third degree tear). Perineal damage can have a major adverse impact on women"s health and mismanagement of perineal trauma is a source of obstetric litigation. Long-term morbidity associated with anatomically incorrect approximation of wounds or unrecognised trauma to the external anal sphincter can lead to major physical, psychological and social problems.

**Classification of perineal tears**

- First degree: injury to the **skin only**
- Second degree: involvement of the **perineal muscles** but not the anal sphincter
- Third degree: injury to the perineum involving the **anal sphincter complex** (external anal sphincter [EAS] and internal anal sphincter [IAS]).
  3a: less than 50% of EAS thickness torn
  3b: more than 50% of EAS thickness torn
  3c: IAS torn
- Fourth degree: injury to the perineum involving the anal sphincter complex AND the **anal epithelium** Third and fourth degree tears are uncommon, probably complicating up to 2.5 to 4% of all deliveries, but they can lead to devastating long-term complications such as faecal incontinence. Diagnosis and satisfactory primary repair is essential.

**Prediction and prevention of anal sphincter tears**

- Risk factors for anal sphincter trauma include:
- Primiparity (up to 4%)
- Birth weight > 4 kg (up to 2%)
- Forceps delivery (up to 4%)
- Shoulder dystocia (up to 4%)
- Occipito-posterior position at delivery (up to 3%)
- Short perineum (<3cms)
- Epidural analgesia (up to 2%)
- Induction of labour (up to 2%)
- Midline episiotomy (up to 3%)

The risk factors identified cannot readily be used to prevent the occurrence of extensive perineal trauma. Delivery in left lateral position or all fours is associated with least trauma. Lithotomy position should be avoided in the final stages of normal birth. The clinician and the woman should work together to achieve a slow and controlled birth, be this „hands on" or „hands poised". Where episiotomy is indicated, the mediolateral technique is recommended, with careful attention to the angle cut away from the midline. Aim at an angle of 450-600 and ensure the cut is sufficient to prevent the episiotomy extending into the anal sphincter.

Who can perform the repair? Be aware of your limitations-if in doubt, call for more experience assistance. Midwives with appropriate skills and experience can repair first degree tears, episiotomies and second degree tears. Assistance should be sought from obstetric team if the midwife has any doubts. Junior obstetric staff can repair first, second and 3rd degree tears with or without supervision depending on experience. Consultant obstetricians can repair all types of perineal tears. A senior obstetrician (senior registrar or consultant) must be involved in deciding who can repair a tear or episiotomy that has completely divided the anal sphincter and/or anorectal mucosa.

Clinical assessment of the perineum and lower vagina Women who have sustained perineal trauma should have

systematic examination of the vagina, perineum and rectum for an accurate evaluation of any trauma sustained prior to suturing and the findings should be clearly documented in the notes. The woman should usually be in lithotomy position with adequate lighting. When non-suturing may be applicable

Where the skin edges of a first degree tear are well apposed, it can be left unsutured and allowed to heal naturally.

Methods and materials used in perineal repair

1. Ensure adequate analgesia.
2. Ensure adequate exposure.
3. Ensure correct apposition of the tissue layers.
4. First degree tears should normally be sutured in order to improve healing (see above when non-suturing may applicable). Vaginal epithelium should be closed with continuous non-locked 2/0 Vicryl rapide® suture and perineal skin with continuous subcuticular 2/0 vicryl rapide® suture.
5. In a second degree tear, perineal muscles should be approximated with continuous 2/0 Vicryl rapide® sutures. The skin is closed in the same way as for a first degree tear. Uncomplicated episiotomies should be repaired in the same manner (extended episiotomies should be repaired by appropriately skilled practitioners).
6. The use of a continuous absorbable subcuticular suture is associated with less short term pain, but the long term effects on pain and dyspareunia are less clear
7. Ensure that swabs, instruments and needle count is correct after the repair has been completed, and that there are no abnormalities on rectal or vaginal examination. Swab and sharp counts should be documented clearly before and after the procedure in the woman"s health record. Wherever possible, two signatures from health professionals are required at both counts.
8. If a swab or instrument is to be left in situ for transfer to theatre for repair, 2 x green bracelets must be placed alongside the ID bracelets on ankle and wrist. These must be removed immediately after removal of swab or instrument.

9. Ensure that adequate post-partum pain relief is prescribed6. This will usually include Diclofenac® 100mg PR unless contraindicated.
10. Ensure that adequate operation notes are made.
11. Advice should be given about perineal hygiene, avoidance of constipation and pelvic floor exercises.

Documentation of consent for all types of perineal repair Verbal consent is adequate for first/second degree perineal tears and uncomplicated – but this should be documented in the notes. For more complicated trauma and for 3rd/4th degree tears written consent must be obtained using the approved procedure-specific consent form.

Management of third- and fourth-degree perineal tears Diagnosis should be confirmed by an obstetrician with appropriate experience. Inform the senior resident obstetrician, who should decide who should repair a tear or episiotomy that has completely divided the anal sphincter and/or anal epithelium. Obtain consent (see above recommendations). Intravenous access should be established and blood sent for FBC/G & S Inform anaesthetist and arrange for the patient to be transferred to theatre, where formal repair can be undertaken with all the advantages of aseptic conditions, good light, good exposure, adequate assistance and appropriate instruments. The inherent tone of the sphincter muscle often causes torn muscle ends to retract, so adequate muscle relaxation is necessary to retrieve the ends and repair them without tension. Therefore, all repairs should be performed under regional (spinal or epidural) or general anaesthesia - it is NOT acceptable for the repair to be attempted using local anaesthetic.

The full extent of the injury should be evaluated by a careful vaginal and rectal examination in the lithotomy position and graded according to the above classification. (NB. In acute obstetric trauma it is not always possible to identify the IAS – but the extent of damage to the EAS should be recorded in all cases). In the presence of a fourth degree tear, the torn anal epithelium should be repaired with interrupted 3/0 Vicryl® sutures with the knots tied in the anal lumen. The sphincter muscles should be repaired using 3/0

PDS® sutures. Although alternatives sutures, such as nylon or Prolene® are also acceptable, they can cause stitch abscesses and the sharp ends can cause discomfort requiring removal. There is some evidence that primary repair of the anal sphincter is best achieved by means of an overlapping repair, rather than conventional end-to-end approximation with a “figure of 8” suture. This suggestion was disputed by a subsequent prospective, randomised controlled trial that compared conventional end-to-end repair and the overlap technique and found no significant differences in continence rates at three months‟ follow-up. Either technique seems to be appropriate. Great care should be exercised in reconstructing the perineal muscles to provide support to the sphincter repair. Muscles of the perineal body are reconstructed with interrupted 2/0 Vicryl® sutures after closing the vaginal epithelium with a continuous 2/0 Vicryl® suture. Finally, the perineal skin should be approximated with a continuous subcuticular suture, as this is associated with less short term perineal pain and wound gaping4.

- A rectovaginal examination is required to confirm complete repair and to ensure that all tampons and swabs have been removed.
- If a swab or instrument is to be left in situ for transfer to theatre for repair, 2 x green bracelets must be placed alongside the ID bracelets on ankle and wrist. These must be removed immediately after removal of swab or instrument.
- Administer prophylactic antibiotics:
    - Cefuroxime 1.5g I.V. and metronidazole 1g P.R. 9,10 followed by five days oral metronidazole 400mg tds and cefradine 500mg qds.
    - If penicillin allergic use Clindamycin 600mg I.V. and Gentamicin 160mg I.V. followed by clindamycin 300mg QDS PO for 5 days
    - Offer rectal Diclofenac® 100mg- unless this is contraindicated6.
- Insert indwelling urinary catheter in all women7.

- Ensure that adequate operation notes are made. Refer to standards of record keeping on page 4.
- Ensure an incident form is completed.
- Prescribe a stool softener (Lactulose® 10ml b.d.) for five days. (Do not prescribe a bulking agent such as Fybogel as it has been shown this increases incontinence rates).
    1. Ensure that adequate analgesia (excluding constipating agents, such as codeine) is prescribed. Postnatal follow up for women who have had third- or fourth-degree tear
    2. Ensure that the patient is seen by one of the obstetric physiotherapists prior to discharge. The physiotherapist will arrange a six-week follow-up appointment. At weekends, the midwife should give the patient the information leaflet on perineal trauma and arrange a physiotherapy appointment.
    3. Ensure that the patient has a twelve-week follow-up appointment in the perineal clinic to see the multi-disciplinary team, during which a careful history should be taken of bowel, bladder and sexual function. A vaginal and rectal examination should be performed to check for complete healing, scar tenderness and sphincter tone. All women with 3B, 3C and 4th degree tears are offered ano rectal manometry and endo anal ultrasound scan. Future delivery is recommended on the basis of these findings and the notes are reviewed by a consultant before recommendations for future delivery are made.

Standards for record keeping in relation to all types of perineal repair

Documentation must include the following:

1. Tear classification
2. Consent for suturing
3. Analgesia/anaesthesia
4. Repair technique and suture material
5. Vaginal and rectal examination at the end of the procedure
6. Documentation of swabs, needles and instrument count
7. Post-operative analgesia

8. Bladder care
9. Name, designation and signature of the clinician, and date
Support following the repair All women who have suffered perineal trauma will be offered the “How to look after your perineum after having a baby” leaflet (M103). Women who have sustained more extensive perineal trauma will also be offered the “Third and Fourth degree perineal tears leaflet (M53). Monitoring of complications of perineal trauma The perineal wound and caesarean section surgical site surveillance form should be completed for all women who sustain a perineal tear. Any women returning to the hospital for review of their perineum following suturing should have the incident reported via the DATIX incident reporting system. There is a specific trigger under Departmental Triggers: Delivery suite; review of perineum.

**Clinical Guideline for: The Management of Perineal Trauma following Childbirth**

| **Element to be monitored** (For NHSLA documents this must include all Level 1 minimum requirements) | **Monitoring Tool / Method of monitoring** | **Frequency of monitoring** | **Lead Responsible for developing action plan & acting on recommendations** | **Reporting arrangements** (Committee or group where monitoring results and action plan progress are reported to) | **Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document** |
|---|---|---|---|---|---|
| **a.** Who can perform the repair | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow | Clinical Governance Lead | Departmental Clinical Governance meeting | The Lead responsible for developing the action plans will disseminate lessons learned |

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| | | guidance | | | via the most appropriate committee e.g. Clinical Effectiveness; Clinical Governance, Patient Safety and where appropriate, the Compliance Assurance Group. |
| **b.** Systematic assessment of the perineum and lower vagina for an accurate evaluation of any trauma sustained | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **c.** When non-suturing may be applicable | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **d.** Methods and materials used in perineal repair | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **e.** Documentation of consent for | A formalised audit with reference to | 3 Yearly audit or when | Clinical Governance Lead | Departmental Clinical Governance | |

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| all types of perineal repair (target 100% exceptions – only when patient having an urgent EUA) | CNST requirements | Clinical risk identified regarding failure to follow guidance | | meeting | |
| **f.** Management of third and fourth-degree tears including: Repair in theatre under GA or regional broad spectrum antibiotics indwelling catheter inserted (100%) | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **g.** A recto-vaginal examination should be performed and documented in all cases to confirm complete repair and ensure that all swabs and | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |

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| tampons have been removed (target - 100%; exceptions – zero) | | | | | |
| **h.** Process for offering a 6 week postnatal appointment with a physiotherapist and a twelve week appointment in the perineal clinic (100%) | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **i.** Standards for record-keeping in relation to all types of perineal trauma | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **j.** Documentation of information given regarding support following the repair | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure | Clinical Governance Lead | Departmental Clinical Governance meeting | |

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| | | to follow guidance | | | |
| **k.** Process for monitoring the rate and cause of returns of women with problems relating to all types of perineal repair | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |
| **l.** Maternity service"s expectations for staff training, as identified in the training needs analysis | A formalised audit with reference to CNST requirements | 3 Yearly audit or when Clinical risk identified regarding failure to follow guidance | Clinical Governance Lead | Departmental Clinical Governance meeting | |

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