Wessex Intrapartum Care Network Pathways

No 5: Management of OASI

Intrapartum risks include:

- OP presentation
- Shoulder dystocia
- Prolonged 2nd stage of labour
- Assisted vaginal birth

Evidence to support

- All fours / lateral position for birth and avoiding lithotomy for SVB
- Routine episiotomy use for AVB
- No increased risk from waterbirth

Follow preferred local bundle for reducing risk of OASI:

OASI care bundle (RCOG):

- AN education about reducing risk of OASI
- Manual perineal protection - for a slow / guided birth
- If indicated - episiotomy at 60 degrees from midline
- Systematic PV/PR examination even if appear intact

PEACHES care bundle:

- P Position
- E Extra midwife (for birth)
- A Assess the perineum throughout
- C Communication / use of warm compress
- H hands-on technique
- E Episiotomy if indication at 60 degrees from midline
- S S-L-O-W-L-Y

RCOG (2015) GTG 29: The Management of Third- and Fourth-Degree Perineal Tears

AN period - Identify OASI risk factors - nulliparity, previous OASI, baby >4kg, short perineum, Asian ethnicity
Give information and signpost to advice: (https://www.rcog.org.uk/tears)

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At birth - Provide management using preferred care bundle. Avoid lithotomy position for SVB. Offer warm compress as perineal tissue is distended.
Following birth - Discuss the assessment sensitively with the mother, offer analgesia and ensure good lighting
Identify extent of perineal trauma by systematic PV and PR assessment before and after suturing. Use standard classification*

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Location of repair: All 3rd and 4th degree tears should be repaired in theatre
Operator: Repair should be undertaken by a Consultant or registrar with appropriate training. (Consider colorectal surgeon assistance for 4th degree tears)
Analgesia: Suturing should be performed with regional or general anaesthetic.

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Technique: Anorectal mucosa should be repaired with sutures using either the continuous or interrupted technique. Where the torn IAS can be identified, it is advisable to repair this separately with interrupted or mattress sutures without any attempt to overlap the IAS. For repair of a full thickness EAS tear, either an overlapping or an end-to-end (approximation) method can be used . For partial thickness (all 3a and some 3b) tears, an end-to-end technique should be used.
Material: 3-0 polyglactin should be used to repair the anorectal mucosa. When repair of the EAS and/or IAS muscle is being performed, use either monofilament sutures such as 3-0 PDS or modern braided sutures such as 2-0 polyglactin.
Consider use of a vaginal pack if excessive bleeding is obscuring clear view.

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Postnatal follow up

- 7 days of antibiotics
- 14 days of laxatives
- Offer / Refer to physiotherapist
- Make recommendations re future births*

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3a tears

- Follow up with GP or obstetric consultant or PPHS (as local policy)

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3b, 3c, 4th degree tears

- Offer Endoanal scan from 3 months onwards with specialist obstetric or urogynaecology follow up (and PPHS if appropriate) - particularly if any pain/incontinence.

***RCOG GTG 29 (2015)**
Third-degree tear: Injury to perineum involving the anal sphincter complex:
Grade 3a tear: Less than 50% of external anal sphincter (EAS) thickness torn.
Grade 3b tear: More than 50% of EAS thickness torn.
Grade 3c tear: Both EAS and internal anal sphincter (IAS) torn.
Fourth-degree tear: Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

***Next birth recommendations**

- 60-80% women asymptomatic within 12 months
- Recurrence risk 5-7%, with 17% women developing worsening faecal symptoms after second vaginal birth
- Aim for vaginal birth if no any bowel symptoms and the muscle well healed
- Planned caesarean birth may be recommended if abnormal endoanal scan / symptomatic
- No evidence for routine episiotomy in next birth - consider individual risks