BIZCOMMUNITY

Managing perineal tears

By Jude Polack

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A perineal tear occurs during childbirth when the tissue around the vaginal opening is damaged and this ranges from mere skin snicks, which heal on their own after childbirth (called first-degree tears), to tears involving vaginal tissue and the perineal muscles, which will need a few stitches in the delivery room (second-degree tears). Far more rare are third- and fourth-degree tears, involving the vaginal tissue, perineal muscles, anal sphincter and at worst, tissue within the rectum. These tears require repair in theatre.

Pain management

Understandably, moms delivering vaginally are often concerned about the pain of tearing. The good news is that you are unlikely to feel the tear during labour, since the skin is stretched taut, making it quite numb. Afterwards however, pain will vary depending on the severity of the tear; in most cases, since the majority of tearing is either first- or second-degree, moms report stinging rather than actual throbbing pain.

Will I definitely get a tear?

The only delivery where a wound is a certainty is a Caesarean section. For a natural birth, the chances of going home with a tear are significantly smaller: around 40% for first-time moms, and 20% in subsequent deliveries, with only 0.6%-0.9% of vaginal deliveries resulting in a severe tear, according to James, Steer, Weiner and Gonik in "High Risk Pregnancy Management Options" (2005, Saunders Elsevier).

What increases my risk of tearing?

Baby's size and position during the birth have a big influence. Babies who are large for their gestational age or over 40 weeks are more likely to cause tearing. Risks also increase with babies born face first or facing mom's front instead of her back, and with those who have a hand, elbow or shoulder protruding.

Mom's position during delivery is another factor. The rate of perineal tearing is higher in a traditional hospital environment where moms are required to deliver on their backs, often with their legs in stirrups; this is a particularly bad position for tear prevention.

Medical intervention also significantly raises the risk, with forceps delivery probably the biggest culprit. Epidurals also have an impact, since they stop moms feeling the urge to push. Moms often end up pushing too early which can lead to a prolonged second stage of labour - a known risk factor in tearing - or they push too hard before the perineum has stretched sufficiently.

An augmented labour, where drugs help labour along, ups the risk further, as contractions are often stronger than normal, which can cause the baby to crown too early and quickly.

Episiotomy not the answer

The accepted thinking used to be that the mom should have an episiotomy rather than risk tearing, but experience has shown that episiotomies, where the doctor or midwife cuts the perineum, do not reduce the severity of tearing. In fact, an episiotomy increases the risk of having a more severe third- or fourth-degree tear. Just think how hard it is to tear material, yet if you make a little nick, the fabric rips easily; the same happens with an episiotomy.

A perineal tear is usually only superficial, running through the skin, whereas an episiotomy cuts right through skin and muscle. This means episiotomies are usually more painful and slower to heal since they are much deeper. The ragged edge of a natural tear is easier to match back if stitches are needed, so the wound heals with less scarring.

Episiotomies are only necessary in emergencies, when your baby needs to come out immediately, and there is no time to allow the perineum to stretch naturally.

How to minimise tearing

There is no way to guarantee that you will not experience some degree of tearing during birth, but there are a number of ways to minimise the risk.

- Perineal massage in the last six weeks of pregnancy can help to soften and stretch the perineum. Ask your antenatal educator or midwife to show you the ropes.
- Emotional readiness for the birth is a big factor. If mom is ready and has done visualisations, then she is not tense and stressed and her muscles are softer.
- If possible, deliver on your hands and knees, which is the best position since baby is not being dragged out against your perineum.
- Even if you are not allowed to deliver on your hands and knees, you can do a lot to ensure a slow, controlled second stage, which is probably the biggest factor in reducing perineal tears. Push very slowly and only when you feel a contraction, and resist doing 'red-faced' pushing. As the baby starts crowning, do not bear down on the contraction. Your midwife or antenatal educator will guide you on this.

What happens if there is a tear?

Your doctor or midwife will stitch second-degree tears under local anaesthetic, while third- and fourth-degree tears will be repaired in theatre.

Good wound care is important; ice packs will help reduce swelling and discomfort. Keep the area clean and do not fiddle with the wound; salt baths are a great way to disinfect your wound while easing the discomfort.

If the wound stings when you go to the loo, pour warm water over the area while you urinate. You can also take stool softeners if it is painful when you have a bowel movement.

Could it be less risky to opt for a Caesarean?

How you decide to have your baby is your personal choice, but remember that whether natural or by Caesarean, there is no pain-free, risk-free way to get a baby out of your body. Neither birth routes are without risks; both have their own set of associated problems, which you should take into consideration.

While you are weighing up your risks of getting a bad perineal tear, also weigh up your chances of having an infected C-section incision that will require surgical repair, which happens in around 4-8% of Caesareans. In addition, while you might be caring for a wound if you give birth naturally, you will definitely be caring for one after a Caesarean.

ABOUT THE AUTHOR

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