

Prevention of perineal tears



Ann Yates

Midwife

Preparing a woman for labour and birth is a fundamental part of antenatal care. For many women, the prospect of damage to their genital tract is of concern and some fear they will never function the same again.

Part of the miracle of birth is the amazing ability of the vagina and perineum to expand and for the baby to navigate the birth canal unaided. The fact that most of us survived this right of passage to give birth again is often no consolation to a first time mum and inevitably the midwife is asked to provide helpful advice and reassurance before the event.

The following points list my personal repertoire of method of prevention for perineal trauma from over 33 years of midwifery practice. Some points are common sense, some points have been confirmed through research to be good practice and some are just comforting for the woman at the time:

1. Good nutrition and health equals strong elastic tissue and rapid healing postpartum. This needs to be discussed antenatally and women require good information to make healthy food choices.
2. Sore, irritated, swollen perineal tissue is not likely to be as pliable, can tear easily and heals badly. Hygiene basics need discussion antenatally – advise to avoid perfumed soaps and sprays and sometimes panty liners can cause irritation. Comfortable cotton underwear should be encouraged. Ensure timely follow-up on vaginal swabs and treatment of yeast or other infections.
3. Perineal massage has been taught in childbirth education for the past 40 years and remains controversial. The concept of stretching of the perineum by placing two thumbs into the introitus and gradually stretching the perineum open and out is thought to be beneficial. Some midwives recommend evening primrose or unscented almond oil for this. Unfortunately, it is physically challenging in later stages of pregnancy and is generally taught as a couple's activity. Evidence on perineal massage is light, other than being shown to be effective for nulliparous women after 34 weeks gestation.¹
4. A dilating balloon device is currently being promoted to increase vaginal elasticity antenatally, however, I am challenged to see the benefits of dilating a woman's vagina to 10cm without actually being in labour and giving birth. The vaginal/perineal tissue does this particularly well when there is gradual dilation in labour, with sufficient expulsive urge, support and encouragement.
5. Management of the second stage of labour is critical to preserving the integrity of the perineum. We should observe the resting (wait and be thankful) or passive phase of second stage labour and wait for physiological urge to push occurs. NICE guidelines² suggest approximately an hour for this to happen and in this time the doctor or midwife should not be guiding or coaching.

There is a significant trend towards poorer perineal outcomes when directed valsalva pushing is used³, with evidence that pushing on command and valsalva/breath-holding contributes to pelvic floor damage, fetal distress, exhaustion and perineal tears.

A meta-analysis of randomised controlled trials showed that spontaneous vaginal birth reduced the incidence of perineal trauma.⁴ There is no clear evidence or consensus about guarding the perineum in the second stage of labour, maternal position in labour (apart from avoidance of lithotomy), or perineal massage in the second stage of labour.^{5,6,7} In my experience, few women elect to lie on their backs during the second stage and describe lithotomy as the most painful position to be in. However, women will instinctively assume a birthing position that works for them.

A comforting midwifery practice is to place warm packs over the perineum to help relieve the burning sensation during crowning. Provide gentle support of haemorrhoids with a warm cloth. There is a traditional midwifery saying: 'Never EVER take your eyes off the perineum to avoid sudden rapid uncontrolled birth'.

6. For some women, the possibility of defecating during active second stage inhibits their efforts. Ina May Gaskin describes this as 'shit shock' and encourages women to open their mouth, drop their jaw and try to keep their lips loose and open. She advocates humour to help women to relax and close interaction between midwife and the woman throughout with gentle coaxing and quiet, peaceful talking to encourage slow birth of the head after crowning.

The most effective preventative for perineal trauma in my experience is the trusting relationship between mother and midwife developed through pregnancy. Discussion occurs about what happens in the second stage and how the midwife will provide encouragement and support to get through this overwhelming and sometimes frightening experience.

References

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