

Information for you

Published in June 2015

A third- or fourth-degree tear during birth (also known as obstetric anal sphincter injury – OASI)

About this information

This information is for you if you want to know more about third- or fourth-degree perineal tears (also known as obstetric anal sphincter injury – OASI). It may be helpful if you are a relative or friend of someone who is in this situation.

What is a perineal tear?

Many women experience tears to some extent during childbirth as the baby stretches the vagina. Most tears occur in the perineum, the area between the vaginal opening and the anus (back passage).

Small, skin-deep tears are known as first-degree tears and usually heal naturally. Tears that are deeper and affect the muscle of the perineum are known as second-degree tears. These usually require stitches.

An episiotomy is a cut made by a doctor or midwife through the vaginal wall and perineum to make more space to deliver the baby.

What is a third- or fourth-degree tear?

For some women the tear may be deeper. A tear that also involves the muscle that controls the anus (the anal sphincter) is known as a third-degree tear. If the tear extends further into the lining of the anus or rectum it is known as a fourth-degree tear.



How common are third- or fourth-degree tears?

Overall, a third- or fourth-degree tear occurs in about 3 in 100 women having a vaginal birth. It is slightly more common with a first vaginal birth, occurring in 6 in 100 women, compared with 2 in 100 women who have had a vaginal birth previously.

What increases my risk of a third- or fourth-degree tear?

These types of tears usually occur unexpectedly during birth and most of the time it is not possible to predict when it will happen. However, it is more likely if:

- this is your first vaginal birth
- you are of South Asian origin
- your second stage of labour (the time from when the cervix is fully dilated to birth) is longer than expected.
- you require forceps or a ventouse to help the delivery of your baby – see RCOG patient information *Assisted vaginal birth (ventouse or forceps)* (www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps)
- one of the baby's shoulders becomes stuck behind your pubic bone, delaying the birth of the baby's body, which is known as shoulder dystocia – see RCOG patient information *Shoulder dystocia* (www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia)
- you have a large baby (over 4 kg or 8 pounds and 13 ounces)
- you have had a third- or fourth-degree tear before.

Could anything have been done to prevent this type of tear?

In most instances, a third- or fourth-degree tear cannot be prevented because it cannot be predicted. However, applying a warm compress to the perineum while you are pushing does appear to reduce the chance of a third- or fourth-degree tear. Your midwife or obstetrician may protect the perineum as your baby's head is delivering and this may also help prevent a tear.

It is unclear whether an episiotomy will prevent a third- or fourth-degree tear from occurring during a normal vaginal birth. An episiotomy will only be performed if necessary, and with your consent.

If you have an assisted birth (ventouse or forceps), you are more likely to have an episiotomy as it may reduce the chance of a third- or fourth-degree tear occurring.

What will happen if I have a third- or fourth-degree tear?

If a third- or fourth-degree tear is suspected or confirmed, this will usually be repaired in the operating theatre. Your doctor will talk to you about this and you will be asked to sign a consent form. You will need an epidural or a spinal anaesthetic, although occasionally a general anaesthetic may be necessary.

You may need a drip in your arm to give you fluids until you feel able to eat and drink. You are likely to need a catheter (tube) in your bladder to drain your urine. This is usually kept in until you are able to walk to the toilet.

After the operation you will be:

- offered pain-relieving drugs such as paracetamol, ibuprofen or diclofenac to relieve any pain
- advised to take a course of antibiotics to reduce the risk of infection because the stitches are very close to the anus
- advised to take laxatives to make it easier and more comfortable to open your bowels.

Once you have opened your bowels and your stitches have been checked to see that they are healing properly, you should be able to go home.

Will I be able to breastfeed?

Yes. None of the treatments offered will prevent you from breastfeeding.

What can I expect afterwards?

After having any tear or an episiotomy, it is normal to feel pain or soreness around the tear or cut for two to three weeks after giving birth, particularly when walking or sitting. Passing urine can also cause stinging. Continue to take your painkillers when you go home.

Most of the stitches are dissolvable and the tear or cut should heal within a few weeks, although this can take longer. The stitches can irritate as healing takes place but this is normal. You may notice some stitch material fall out, which is also normal.

To start with, some women feel that they pass wind more easily or need to rush to the toilet to open their bowels. Most women make a good recovery, particularly if the tear is recognised and repaired at the time: 6–8 in 10 women will have no symptoms a year after birth.

What can help me recover?

Keep the area clean. Have a bath or a shower at least once a day and change your sanitary pads regularly (wash your hands both before and after you do so). This will reduce the risk of infection.

You should drink at least 2–3 litres of water every day and eat a healthy balanced diet (fruit, vegetables, cereals, wholemeal bread and pasta). This will ensure that your bowels open regularly and will prevent you from becoming constipated.

Strengthening the muscles around the vagina and anus by doing pelvic floor exercises can help healing. It is important to do pelvic floor exercises as soon as you can after birth. You should be offered physiotherapy advice about pelvic floor exercises to do after surgery.

Looking after a newborn baby and recovering from an operation for a perineal tear can be hard. Support from family and friends can help.

When should I seek medical advice after I go home?

You should contact your midwife or general practitioner if:

- your stitches become more painful or smelly – this may be a sign of an infection
- you cannot control your bowels or flatus (passing wind).

Talk to your GP if you have any other worries or concerns. You can be referred back to the hospital before your follow-up appointment if you wish.

When can I have sex?

In the weeks after having a vaginal birth, many women feel sore, whether they've had a tear or not. If you have had a tear, sex can be uncomfortable for longer. You should wait to have sex until the bleeding has stopped and the tear has healed. This may take several weeks. After that you can have sex when you feel ready to do so.

A small number of women have difficulty having sex and continue to find it painful. Talk to your doctor if this is the case so that you can get the help and support you need.

It is possible to conceive a few weeks after your baby is born, even before you have a period. You may wish to talk with your GP or midwife about contraception or visit your local family planning clinic to discuss this.

Your follow-up appointment

You may be offered a follow-up appointment at the hospital 6–12 weeks after you have had your baby to check that your stitches have healed properly. You will be asked questions about whether you have any problems controlling your bowels. You may be referred to a specialist if you do.

You will also have the opportunity to discuss the birth and any concerns that you may have.

Can I have a vaginal birth in the future?

Most women go on to have a straightforward birth after a third- or fourth-degree tear.

However, there is an increased risk of this happening again in a future pregnancy. Between 5 and 7 in 100 women who have had a third- or fourth-degree tear will have a similar tear in a future pregnancy.

You may wish to consider a vaginal delivery if you have recovered well and do not have any symptoms. If you continue to experience symptoms from the third- or fourth-degree tear, you may wish to consider a planned caesarean section.

You will be able to discuss your options for future births at your follow-up appointment or early in your next pregnancy. Your individual circumstances and preferences will be taken into account.

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd JL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-83



<http://www.advancingqualityalliance.nhs.uk/SDM/>

Further Information and support

Bladder and Bowel Foundation: www.bladderandbowelfoundation.org

RCOG patient information:

- *Assisted vaginal birth (ventouse or forceps)*: www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps
- *Shoulder dystocia*: www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guideline *The Management of Third- and Fourth-Degree Perineal Tears* (June 2015). The guideline contains a full list of the sources of evidence we have used. You can find it online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg29.

This leaflet was reviewed before publication by women attending clinics in Ayrshire, London and Staffordshire, and by the RCOG Women's Network.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.