



PIPADOR REVISION

MRCOG Part 1 Revision Notes

Episiotomy & Perineal Tears

ANATOMY • LECTURE 20

VISUAL EXAMINATION REVISION NOTES

2026 Edition

MRCOG Part 1 Revision Notes

Lecture 20: Episiotomy and Perineal Tears

Anatomy • Visual revision edition

COLOUR CODE USED THROUGHOUT THESE NOTES

SKIN / MUCOSA	PERINEAL MUSCLES	EXTERNAL SPHINCTER	INTERNAL SPHINCTER	MEDIOLATERAL / SAFE
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LEARNING OBJECTIVES — tick off as you go

- ☐ Classify perineal trauma (1st–4th degree; OASI subtypes 3a, 3b, 3c).
- ☐ List indications for episiotomy.
- ☐ Compare mediolateral and midline episiotomy.
- ☐ Describe surgical technique and repair principles.
- ☐ Outline the OASI Care Bundle.
- ☐ Recognise complications and follow-up.
- ☐ Counsel for future delivery after OASI.

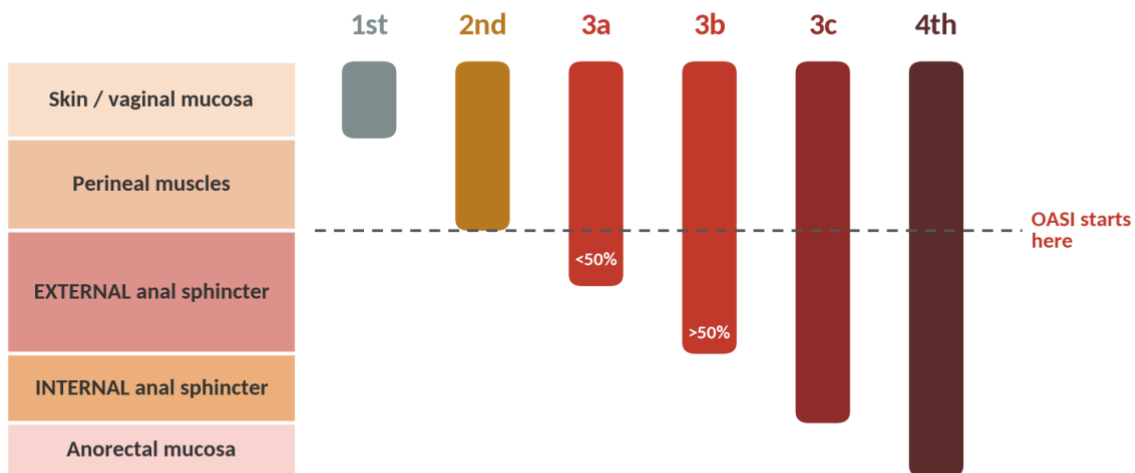
1 Overview

~85% of vaginal births have some perineal trauma	2.9% OASI overall (RCOG)	6.1% OASI in first births	1.7% OASI in multiparous women
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Most tears are 1st or 2nd degree. OASI matters because of faecal incontinence, dyspareunia, chronic pain and psychological harm.

2 Classification (RCOG GTG 29)

How deep does it go? — RCOG classification



'Buttonhole' tear of the rectal mucosa with an INTACT sphincter is not a 4th-degree tear — classify and document separately.

Figure 1. Each degree is defined by the deepest layer torn.

Degree	Injury
1st	Perineal skin and/or vaginal mucosa only
2nd	Perineal muscles (bulbospongiosus, transverse perinei) — sphincter intact; includes most episiotomies
3a	< 50% of EAS thickness
3b	> 50% of EAS thickness
3c	EAS and IAS
4th	EAS + IAS + anorectal mucosa

MNEMONIC / MEMORY HOOK

'Skin, Muscle, Sphincter, Sphincter-plus-mucosa' = 1-2-3-4. Inside the 3rds: a = <half EAS, b = >half EAS, c = the IAS joins in. If in doubt, classify the HIGHER degree.

- Also document anterior trauma: labial, clitoral, periurethral and vaginal wall tears.

3 Risk Factors for OASI

Factor	Effect
Forceps delivery	Biggest single risk factor
Vacuum delivery	Increased (less than forceps)
Primiparity	6.1% vs 1.7%
Birthweight > 4 kg	~2-fold

Factor	Effect
Persistent occipito-posterior	Increased
Asian (esp. South Asian) ethnicity	~2-fold
Prolonged second stage; shoulder dystocia	Increased
Midline episiotomy	Increased vs mediolateral
Previous OASI	Recurrence ~5–7%

4 Episiotomy

IN ONE LINE: A surgical cut of the perineum and posterior vaginal wall in the second stage. Use it **SELECTIVELY** — routine episiotomy does no good.

INDICATIONS

- Suspected fetal compromise — to expedite birth
- Instrumental birth (especially forceps / first instrumental)
- Shoulder dystocia — room for manoeuvres
- Rigid or scarred perineum
- Anterior FGM (de-infibulation)
- Preterm birth — controversial

TECHNIQUE

- Analgesia: 10 mL 1% lidocaine, pudendal block or regional
- Cut at **crowning**, perineum distended
- Start at the fourchette, **60° from the MIDLINE**, usually to the right
- Single cut, sharp scissors (**Episcissors-60**); ~4 cm
- Through skin, vaginal mucosa, bulbospongiosus, superficial transverse perineal

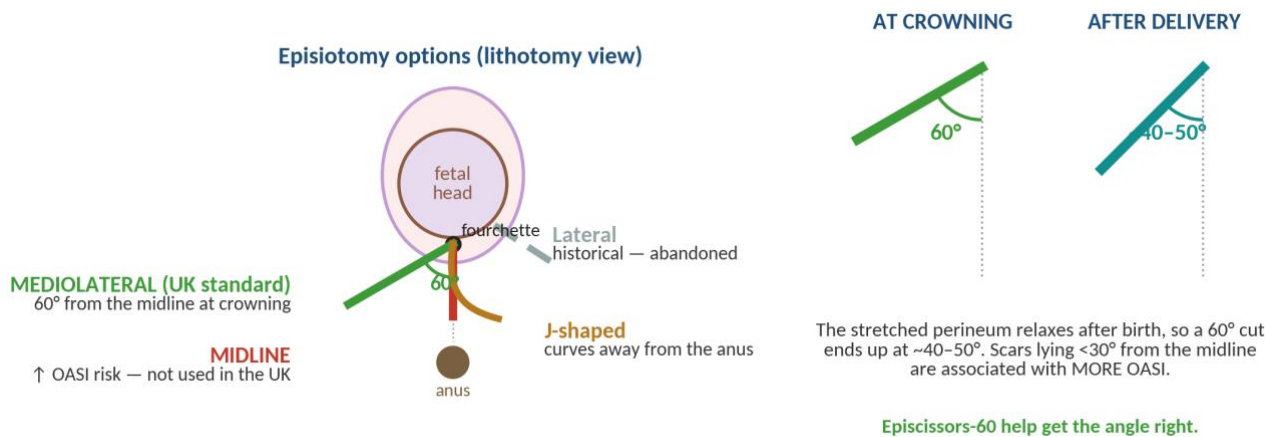


Figure 2. Episiotomy types — and why 60° at crowning matters.

Type	Description	Pros	Cons
Mediolateral	60° from the midline at crowning; usually right-sided; UK standard	Lower OASI than midline	More blood loss and pain; harder repair
Midline	Straight back towards the anus	Less bleeding, easy repair	Much higher OASI risk — not used in UK
J-shaped	Midline, then curves laterally	May reduce OASI vs midline	Little evidence

Type	Description	Pros	Cons
Lateral	Starts away from the midline	—	Vessel/nerve injury; abandoned

5 Repair

BEFORE ANY REPAIR

- Good light, assistant, lithotomy, asepsis
- Adequate analgesia
- **Systematic assessment including PR** — every woman
- Find the apex of the vaginal tear

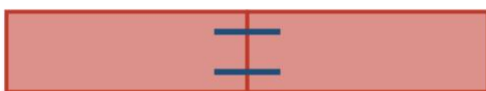
1st / 2nd DEGREE

- Continuous (non-locked) rapidly absorbed polyglactin
- Vaginal mucosa from above the apex to the hymen
- Perineal muscles — close dead space
- Skin: **subcuticular** (less pain)
- PR after repair; swab and needle count

OASI repair — in THEATRE, under regional or general anaesthesia, from the inside out

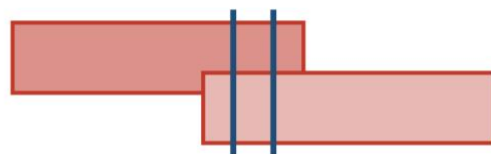


END-TO-END



ends butted together

OVERLAP



ends overlapped ~1.5 cm (full-thickness only)

IAS: always end-to-end. EAS: overlap may give less faecal urgency at 12 months (full thickness only).

Figure 3. OASI repair sequence and sphincter techniques.

6 After an OASI

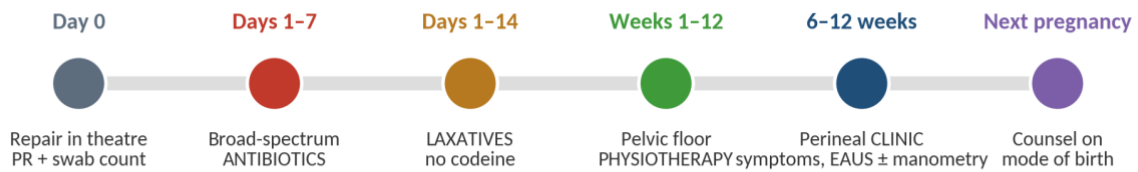


Figure 4. The first year after an OASI.

- **Broad-spectrum antibiotics** (e.g. co-amoxiclav, or cefuroxime + metronidazole), usually 5–7 days.
- **Laxatives** (e.g. lactulose) ~10–14 days; analgesia with paracetamol ± NSAIDs; **avoid codeine** (constipation).
- Physiotherapy; review at **6–12 weeks** in a perineal clinic — St Mark's/Wexner score, examination, endoanal USS ± manometry if symptomatic.

7 The OASI Care Bundle (RCOG / RCM)

1 ANTENATAL INFORMATION	2 MANUAL PERINEAL PROTECTION	3 MEDIOLATERAL EPISIOTOMY	4 PR EXAMINATION
Talk about OASI and perineal protection with every woman	One hand slows the head, the other supports the perineum; controlled, breathed-out delivery	Only when indicated — 60° from the midline at crowning	After EVERY vaginal birth — 'every woman, every birth'

MNEMONIC / MEMORY HOOK

'Talk, Hold, Cut right, Check' — the four steps of the OASI Care Bundle.

8 Complications

SHORT TERM

- Bleeding, pain
- Haematoma (vulval, paravaginal, ischioanal)
- Infection, dehiscence
- Urinary retention
- Difficult first bowel action

LONG TERM

- Faecal incontinence (urge, passive, flatus)
- Dyspareunia, chronic pain, sexual dysfunction
- Psychological harm (PTSD, depression)
- Rectovaginal fistula, anal stenosis (rare)
- Recurrence next pregnancy

9 Next Birth After OASI

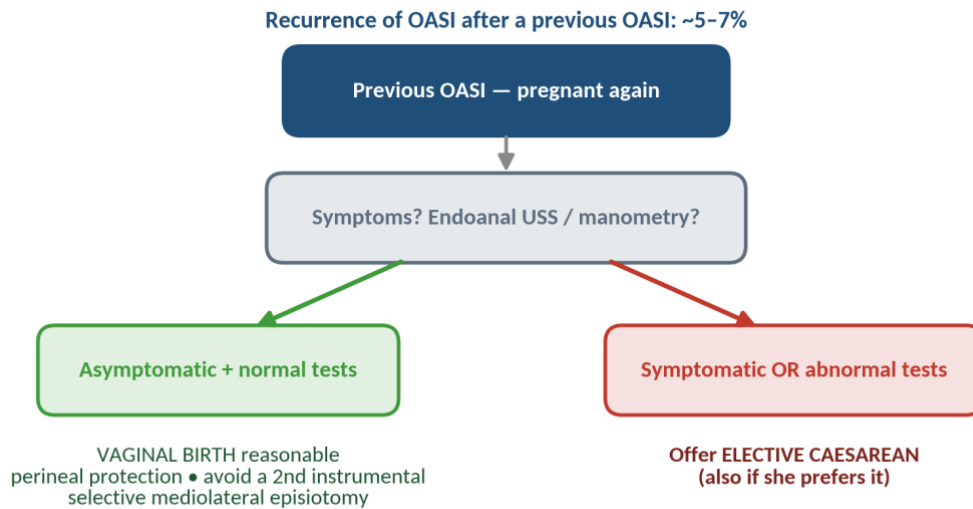


Figure 5. Counselling for the next birth.

10 Prevention

- Antenatal perineal massage from ~35 weeks (first births) • warm compresses in the second stage • slow, controlled delivery of head and shoulders • manual perineal protection.
- Selective mediolateral episiotomy at the correct angle • **vacuum preferred to forceps** where either would do • adequate analgesia • consider lateral or all-fours positions.

11 Special Situations and Clinical Links

FGM • Type III: de-infibulation (anterior episiotomy) — ideally antenatally • Re-infibulation is illegal in the UK	DOCUMENTATION • Indication, type, side and angle of episiotomy • Anaesthetic used; repair technique and sutures • PR findings — every birth • Estimated blood loss; advice given
FAECAL INCONTINENCE AFTER OASI • A substantial minority have bowel symptoms; urgency commonest • Endoanal USS, manometry • Physio, biofeedback, secondary sphincteroplasty, sacral neuromodulation	DYSpareunia, Pain, Dehiscence • Scar, narrowing, granulation, infection, vaginismus — lubricants, oestrogen, trainers, physio • Acute pain usually settles in 1–2 weeks • Dehiscence: obesity, smoking, infection, haematoma — antibiotics, debride, delayed repair

12 MRCOG Exam Pearls — Last-Minute Page

Numbers to know

2.9% OASI overall	6.1% OASI first births	60° From midline at crowning	~4 cm Episiotomy length
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5–7 d

Antibiotics

10–14 d

Laxatives

6–12 wk

Perineal clinic

5–7%

Recurrence of OASI

HIGH-YIELD CHECKLIST

- ☐ 1st skin/mucosa; 2nd muscles; 3a <50% EAS; 3b >50% EAS; 3c + IAS; 4th + anorectal mucosa.
- ☐ OASI 2.9% overall; 6.1% primiparous; 1.7% multiparous.
- ☐ Forceps = biggest single risk factor; also South Asian ethnicity, big baby, OP, midline episiotomy.
- ☐ Mediolateral episiotomy: 60° from the midline at crowning (~40–50° afterwards).
- ☐ PR examination after every vaginal birth.
- ☐ OASI Care Bundle: information, manual perineal protection, correct episiotomy, PR exam.
- ☐ OASI repair in theatre, regional/GA, trained operator.
- ☐ IAS end-to-end (never overlap); EAS overlap or end-to-end if full thickness, end-to-end if partial.
- ☐ Aftercare: antibiotics, laxatives, no codeine, physio, 6–12 week clinic.
- ☐ Next birth: vaginal if asymptomatic with normal tests; offer CS if symptomatic or abnormal.
- ☐ Buttonhole rectal tear with intact sphincter is not a 4th-degree tear.
- ☐ Never re-infibulate after de-infibulation for FGM.

Quick-fire self-test — cover the right-hand column

Question	Answer
Tear through <50% of the EAS?	3a
EAS and IAS torn, rectal mucosa intact?	3c
Biggest single risk factor for OASI?	Forceps delivery
Episiotomy angle at crowning?	60° from the midline
Why avoid a midline episiotomy?	Much higher OASI risk
How is the IAS repaired?	End-to-end, separately (no overlap)
EAS repair for a 3a tear?	End-to-end
Analgesic to avoid after OASI repair?	Codeine
Four parts of the OASI Care Bundle?	Information, perineal protection, correct episiotomy, PR exam
Recurrence risk of OASI?	~5–7%
Symptomatic after OASI, abnormal EAUS — next birth?	Offer elective caesarean

13 References

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- RCOG/RCM OASI Care Bundle. 2017.
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