**LACERATION OF THE GENITAL TRACT**

**Perineal laceration**

Laceration of the perineum are divided into 3 categories

First degree:- laceration involves; involves the skin of the fourchette

Second degree:- laceration (and episiotomy) involves the skin of the fourchette, the perineum and perineal body

Third degree:- laceration involves the skin of the fourchette, the perineum ,perineal body and anal sphincter

**Repair:** laceration s are repaired with catgut sutures and occasionally nylon for the skin sutures. The area must be kept as clean and dry as possible to promote healing and sutures are removed from 5th to 7th day.

3rd degree lacerations are serious as involvement Some give no additional care and others a complex treatment including a low residue diet, confining the bowels for several days and bed rest to assist healing. Of the anal sphincter could lead to feacal incontinence

Other types of lacerations include labial laceration, vaginal and cervical laceration.

Stretching Prolonged , repeated or extreme stretching of the pelvic muscles cause permanent damage in that they never regain their former tone and elasticity. If these muscles fail to support the pelvic organs , prolapse results. This may occur in the course of a prolonged or difficult labour, especially if the baby is very large. More commonly it occurs in grande multiparous women

Utero vaginal prolapse - the vaginal walls are weakened and the uterus lies lower than normal

Cystocele - the upper anterior wall is lax and allows the bldder to bulge into the vagina

Urethrocele - the urethra bulges into the lower anterior vaginal wall

Rectocele- the posterior vaginal wall is damaged, and the rectum bulges into the vagina

To avoid extreme and prolonged stretching of these tissues episiotomy and forceps delivry are undertaken

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EPISIOTOMY

An **episiotomy** also known as **perineotomy**, is a surgical incision of the [perineum](http://en.wikipedia.org/wiki/Perineum) and the posterior vaginal wall generally done by a midwife or obstetrician during second stage of labor to quickly enlarge the opening for the baby to pass through. The incision, which can be done at a 90 degree angle from the [vulva](http://en.wikipedia.org/wiki/Vulva) towards the [anus](http://en.wikipedia.org/wiki/Anus) or at an angle from the posterior end of the vulva (medio-lateral episiotomy), is performed under [local anesthetic](http://en.wikipedia.org/wiki/Local_anesthetic) ([pudendal anesthesia](http://en.wikipedia.org/wiki/Pudendal_anesthesia" \o "Pudendal anesthesia)), and is [sutured](http://en.wikipedia.org/wiki/Surgical_suture) closed after delivery. It is one of the most common medical procedures performed on women, and although it’s routine use in childbirth has steadily declined in recent decades.

**Uses**

Episiotomy is done as [prophylaxis](http://en.wikipedia.org/wiki/Prophylaxis#Prophylaxis) against [soft-tissue](http://en.wikipedia.org/wiki/Soft-tissue) tearing which would involve the anal sphincter and rectum. Vaginal tears can occur during childbirth, most often at the vaginal opening as the baby's head passes through, especially if the baby descends quickly. Tears can involve the perineal skin or extend to the muscles and the anal sphincter and anus. The midwife or obstetrician may decide to make a surgical cut to the perineum with scissors or a [scalpel](http://en.wikipedia.org/wiki/Scalpel) to make the baby's birth easier and prevent severe tears that can be difficult to repair. The cut is repaired with stitches (sutures). Some childbirth facilities have a policy of routine episiotomy.

**Indications**

* There is a serious risk to the mother of second- or third-degree tearing
* In cases where a natural delivery is adversely affected, but a [Caesarean section](http://en.wikipedia.org/wiki/Caesarean_section) is not indicated
* "Natural" tearing will cause an increased risk of maternal disease being vertically transmitted
* The baby is very large
* When perineal muscles are excessively rigid
* When instrumental delivery is indicated
* When a woman has undergone FGM ([female genital mutilation](http://en.wikipedia.org/wiki/Female_genital_mutilation)), indicating the need for an anterior and or mediolateral episiotomy
* Prolonged late decelerations or fetal [bradycardia](http://en.wikipedia.org/wiki/Bradycardia) during active pushing
* The baby's shoulders are stuck ([shoulder dystocia](http://en.wikipedia.org/wiki/Shoulder_dystocia)), or a bony association (Note that the episiotomy does not directly resolve this problem, but it is indicated to allow the operator more room to perform maneuvers to free shoulders from the pelvis)

**Types**

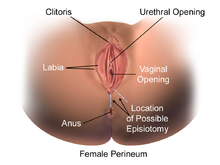
[](http://en.wikipedia.org/wiki/File:Blausen_0355_Episiotomy.png)

Illustration of midline and medio-lateral incision sites for possible episiotomy.

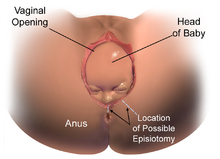
[](http://en.wikipedia.org/wiki/File:Blausen_0294_Delivery_Crowning.png)

Illustration of infant crowning and midline and medio-lateral incision sites for possible episiotomy during delivery.

There are four main types of episiotomy:

* Medio-lateral: The incision is made downward and outward from the midpoint of the [fourchette](http://en.wikipedia.org/wiki/Frenulum_of_labia_minora) either to the right or left. It is directed diagonally in a straight line which runs about 2.5 cm (1 in) away from the [anus](http://en.wikipedia.org/wiki/Anus) (midpoint between the anus and the [ischial tuberosity](http://en.wikipedia.org/wiki/Tuberosity_of_the_ischium)).
* Median: In the midline episiotomy, the incision commences from the centre of the fourchette and extends on the posterior side along the midline for 2.5 cm (1 in).
* Lateral: The incision starts from about 1 cm (0.4 in) away from the centre of the fourchette and extends laterally. Drawbacks include the chance of injury to the [Bartholin's duct](http://en.wikipedia.org/wiki/Bartholin%27s_duct), therefore some practitioners have strongly discouraged lateral incisions.
* *J*-shaped: The incision begins in the centre of the fourchette and is directed posteriorly along the midline for about 1.5 centimetres (0.59 in) and then directed downwards and outwards along the 5 or 7 o'clock position to avoid the [anal sphincter](http://en.wikipedia.org/wiki/Anal_sphincter). This procedure is also not widely practiced.

### Impacts on sexual intercourse

* Some midwives compare routine episiotomy to [female circumcision](http://en.wikipedia.org/wiki/Female_genital_mutilation). One study found that women who underwent episiotomy reported more [painful intercourse](http://en.wikipedia.org/wiki/Painful_intercourse) and insufficient lubrication 12–18 months after birth, but did not find any problems with orgasm or arousal

**Procedure for cutting an episiotomy**

***Instrument***

Episiotomy scissors

Zylocaine 1% or 2% (plain)

Syriges and needles

Water for injection

Swabs

Lotions (Savlon)

Sterile gloves

Chromic catgut 2/0

Needle holder

Dissecting forceps

Artery forceps

***Procedure***

Set tray with delivery instrument

Inform client

Provide privacy

Put on apron

Put on facemask

Wash and dry hands

Put on sterile gloves

Apply drapings

Clean perineum with antiseptic lotion

Explain importance of infiltration

Insert two fingers into the vagina along the line of the proposed incision to protect the fetal head

Insert needle beneath the skin for 4-5cm following same line

Infiltrate perineum in fan like manner

Give incision during contraction when the perineum is thinned, pale and siny

As the head distends the perineum, insert two fingers of the hand between the head and fourchette and make a medio- lateral cut in swift motion

Apply pad on episiotomy site to prevent bleeding

Deliver the head with contraction

Inspect perineum, vagina and cervix

Suture the episiotomy incision

Make patient comfortable

Report as you go along