LATERAL RUPTURE OF THE PERINEUM

A Case Report

by

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Due to inadequate antenatal and obstetric facilities perineal tears of different degrees are frequently met with, but lateral perineal tear is extremely rare and hence this case is reported.

Case Report

The patient, a Hindu female, age 30 years, was admitted in Mayo Hospital on 1-7-62. She had delivered at home 3 days back. It had been a normal and very quick delivery as related by the patient. Obstetrics History. She had 3 F.T. N.D., all home deliveries. On examination, the general condition of the patient was quite satisfactory and cardio-vascular system did not show any abnormality. On the abdomen there was a scar which the patient said was due to splenectomy done 18 years bask.

Vaginal Examination. There was complete perineal rupture, parallel and lateral to the left labium majus, communicating internally with a rent in the left lateral wall of the vagina in its lower one-third. Through this rent the foetus and the placenta were delivered. The introitus was not patulous as expected immediately after delivery. Vulva was intact. Urethra and anus were not damaged. Perineal body was intact but the left levator ani was torn. Pelvis was clinically adequate. The child was quite healthy and weighed 6½ lbs.

This patient was shown to me the next day of admission. There was slight infection and oedema was present at the region of the tear. The patient was taken to the theatre and repair was carried out under spinal. To effect adequate repair the bridge of tissue at the lower end of vagina was severed and the parts were approximated as in third degree perineal tear. Chromic catgut No. 1 was used throughout the repair except the skin which was stitched with nylon.

Post-operative Period. The patient was given prophylactic A.T.S. and A.G.S. and was kept on intra-muscular terramycin.

A self-retaining catheter was put in for 48 hours.

Washes were given and dressing with glycerin-acriflavin locally was applied. She was given liquid paraffin, one tablespoonful twice daily, to keep the motion soft and to prevent tension on the sutures by loaded rectum, as against the old practice of constipating the patient for five days in the post-operative period. She was kept on low residue diet.

First few days after removing the stitches the patient had anal incontinence but gradually it disappeared by the time the patient was discharged. Stitches were removed on 12-7-62 when the oedema of vulva subsided altogether and the wound had healed satisfactorily.

The patient had no temperature during

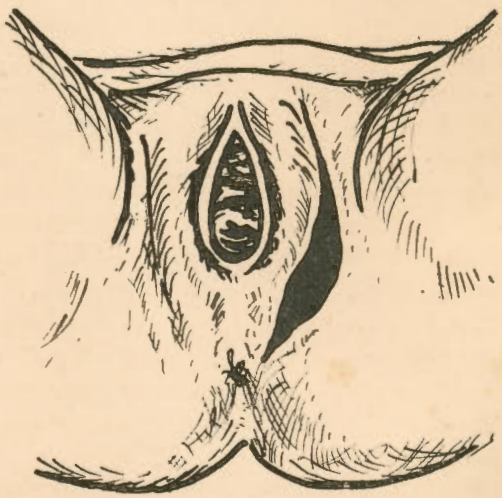

Fig. 1

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the post-operative period. She was discharged on 20-7-62 i.e. 8 days after the stitches were removed as we felt she would not come for immediate post-operative follow up.

Comments

The perineum ruptures very rarely either laterally or near its mid-point allowing the escape of the foetus through the rent. The tear sometimes extends into the rectum behind but leaves a bridge of issue across the lower part of vagina in front. The perineal rupture is favoured by (1) excessive softness of the perineal body, (2) unusual regid condition of the vaginal interoitus, (3) very narrow subpublic arch, (4) very long perineum, (5) or scarring from previous repair as in the case of Josephine Barnes. It is also ascribed to narrow outlet.

Josephine Barnes reviewed the literature and described a case in which a perineal repair was done at the first confinement by a midwife; at the second confinement a very strong contraction pushed the baby through the weak lower vagina into the labia majora. This patient who was admitted in Mayo Hospital has had 3 full-term normal deliveries conducted at home. The birth trauma might have weakened the vagina causing scarring of perineum, with the result that very strong labour pains had pushed the head downwards and backwards through the weak vagina due to unyielding perineum causing lateral perineal tear.

A. Bell (1951) described the protrusion of a foot through anus during spontaneous breech delivery in a primigravida. He replaced the foot in the vagina and after episiotomy delivered the child. Following this he repaired the rectum and vagina with excellent results.

A similar case was described by Munro Kerr (1949).

Usually the repairs are done immediately after the delivery, but in this case the patient had come 3 days after delivery. Considering the infection at the site of the tear and the time elapsed, two alternatives were possible. Either to wait for three weeks as advised by Malpas and Munro Kerr till the sepsis and oedema have completely subsided or to do immediate repair. If repair is postponed there is likelihood that the injured edges of the levator ani will recede and approximation of the cut edges will be difficult. The perineal tissues are used to bacterial contamination and hence heal well in presence of mild infection as in this case.

Summary

A case of lateral perineal tear is reported, as it is extremly rare. There is no report on lateral perineal tear since a case report by Josephine Barnes and review of literature in 1947.

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